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Supreme Court, U.S.
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No. 14-__

IN THE
Supreme Court of the United States

DAVID KING; DOUGLAS HURST;
BRENDA LEVY; and ROSE LUCK,
Petitioners,

v.

SYLVIA MATHEWS BURWELL, as U.S. Secretary of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; JACOB LEW, as U.S. Secretary of the Treasury; UNITED STATES DEPARTMENT OF THE TREASURY; INTERNAL REVENUE SERVICE; and JOHN KOSKINEN, as Commissioner of Internal Revenue,
Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Section 36B of the Internal Revenue Code, which was enacted as part of the Patient Protection and Affordable Care Act ("ACA"), authorizes federal tax-credit subsidies for health insurance coverage that is purchased through an "Exchange established by the State under section 1311" of the ACA.

The question presented is whether the Internal Revenue Service ("IRS") may permissibly promulgate regulations to extend tax-credit subsidies to coverage purchased through Exchanges established by the federal government under section 1321 of the ACA.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

Petitioners, who were Plaintiffs-Appellants in the court below, are four individuals: David King, Douglas Hurst, Brenda Levy, and Rose Luck.

Respondents, who were Defendants-Appellees in the court below, are Sylvia Mathews Burwell (as U.S. Secretary of Health and Human Services); the United States Department of Health and Human Services; Jacob Lew (as U.S. Secretary of the Treasury); the United States Department of the Treasury; the Internal Revenue Service; and John Koskinen (as Commissioner of Internal Revenue).

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The Fourth Circuit's opinion (Pet.App.1a) has not yet been published, but can be found at 2014 U.S. App. LEXIS 13902. The district court's opinion (Pet.App.42a) is at 2014 U.S. Dist. LEXIS 20019.

JURISDICTION

The Fourth Circuit entered judgment on July 22, 2014. Pet.App.1a. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Relevant statutory provisions are reproduced in the Appendix (Pet.App.76a).

STATEMENT OF THE CASE

This is a challenge to the most consequential regulation promulgated under the Patient Protection and Affordable Care Act ("ACA"). Two Courts of Appeals have squarely divided over its facial validity. The resulting uncertainty over this major plank of ACA implementation means that millions of people have no idea if they may rely on the IRS's promise to subsidize their health coverage, or if that money will be clawed back. Employers in 36 states have no idea if they will be penalized under the ACA's employer mandate, or are effectively exempt from it. Insurers have no idea if their customers will pay for health coverage in which they enrolled, or if large numbers will default. And the Treasury has no idea if *billions* of dollars being spent each *month* were authorized by Congress, or if these expenditures are illegal. Only this Court can definitively resolve the matter; it is imperative that the Court do so as soon as possible.

A. For Constitutional Reasons, the ACA Encourages Rather Than Compels States To Establish Exchanges, And It Does So Principally by Limiting Subsidies to State-Established Exchanges.

The ACA regulates the individual health insurance market primarily through insurance "Exchanges." An Exchange is a means of organizing the insurance marketplace to help individuals and small businesses shop for coverage and compare available plans based on price, benefits, and services.

Section 1311(b)(1) of the ACA urges states, in the strongest possible terms, to establish Exchanges. It provides: "Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange ... for the State." 42 U.S.C. § 18031(b)(1). Under the Constitution's core federalism commands, however, Congress cannot *compel* sovereign states to create Exchanges. *Printz v. United States*, 521 U.S. 898, 935 (1997). The Act therefore recognizes that some states may not be "electing State[s]," because they may choose not "to apply the requirements" for an Exchange or otherwise "fai[l] to establish [an] Exchange." ACA § 1321(b)-(c), *codified at* 42 U.S.C. § 18041(b)-(c). To address that scenario, the Act authorizes the Department of Health and Human Services ("HHS") to establish fallback Exchanges in states that do not establish their own. In such cases, the Secretary "shall ... establish and operate such Exchange within the State." ACA § 1321(c), *codified at* 42 U.S.C. § 18041(c). Thus, if a state declines the role that the ACA urges it to accept, that obligation falls upon the federal government instead.

Congress used a variety of "carrots" and "sticks" to induce states to establish Exchanges voluntarily. For example, the Act authorizes federal grants to states for "activities ... related to establishing an [Exchange]." ACA § 1311(a), *codified at* 42 U.S.C. § 18031(a). It also penalizes states that do not create Exchanges, such as by barring them from narrowing their state Medicaid programs until "an Exchange established by the State ... is fully operational." ACA § 2001(b)(2), *codified at* 42 U.S.C. § 1396a(gg).

Most importantly, the Act authorizes subsidies for individual health coverage purchased through *state*-established Exchanges. These subsidies take the form of refundable tax credits, paid by the U.S. Treasury directly to the taxpayer's insurer as an offset against premiums. ACA § 1401(a), § 1412, *codified at* 26 U.S.C. § 36B; 42 U.S.C. § 18082.

Critically, the Act only subsidizes coverage through an Exchange *established by a state*. The Act provides that a credit "shall be allowed" in an "amount," 26 U.S.C. § 36B(a), based on the number of "coverage months of the taxpayer occurring during the taxable year," *id.* § 36B(b)(1). A "coverage month" is a month during which "the taxpayer ... is covered by a qualified health plan ... enrolled in through an Exchange *established by the State under section 1311* of the [ACA]." *Id.* § 36B(c)(2)(A)(i) (emphasis added). Unless the citizen buys coverage through a state-established Exchange, there are no "coverage months" and so no subsidy. Confirming that, the subsidy for any particular "coverage month" is based on premiums for coverage that was "enrolled in through an Exchange established by the State under [§] 1311 of the [ACA]," *id.* § 36B(b)(2)(A).

These inducements for states to establish their own Exchanges were compelled by political realities. The House of Representatives initially enacted a bill under which the *federal government* would create a national Exchange, though individual states could affirmatively choose to establish their own. H.R. 3962, § 308, 111th Cong. (2009). That scheme, however, was unacceptable to the Senate. *See Halbig v. Sebelius*, No. 13-623, 2014 U.S. Dist. LEXIS 4853, at *61 (D.D.C. Jan. 15, 2014) ("[T]hese proposals proved politically untenable and doomed to failure in the Senate ...."). Senator Ben Nelson of Nebraska, whose vote was critical to passage, called the national Exchange a "dealbreaker," expressing concern that such federal involvement would "start us down the road of ... a single-payer plan." Carrie Budoff Brown, *Nelson: National Exchange a Dealbreaker*, POLITICO, Jan. 25, 2010. For Nelson and other swing Senators, it was important to keep the federal government *out* of the process. It was thus insufficient to merely allow states the *option* to establish Exchanges, as the House bill did. Rather, states had to take the leading role, which, given the constitutional bar on compulsion, required serious incentives to induce state participation.

The robust incentives provided by the ACA—in particular, the conditioning of tax credits on state-run Exchanges—were thought sufficient to do so. As one of the Act's architects, Prof. Jonathan Gruber, later explained, "if you're a state and you don't set up an Exchange, that means your citizens don't get their tax credits. ... I hope that's a blatant enough political reality that states will get their act together and realize there are billions of dollars at stake here in setting up these Exchanges, and that they'll do it."

Jonathan Gruber at Noblis, at 32:00 (Jan. 18, 2012), https://www.youtube.com/watch?v=GtnEmPXEpr0&feature=youtu.be&t=31m25s.

Perhaps in light of that "political reality" deterring states from turning down billions of free federal dollars, "lawmakers assumed that every state would set up its own exchange." Robert Pear, *U.S. Officials Brace for Huge Task of Operating Health Exchanges*, N.Y. TIMES, Aug. 4, 2012, at A17. "Congress did not expect the states to turn down federal funds and fail to create and run their own Exchanges." Pet.App.70a. Accordingly, for example, Congress did not appropriate *any* funds in the ACA for HHS to build Exchanges, even as it appropriated unlimited funds to help states establish theirs. *See* ACA § 1311(a), *codified at* 42 U.S.C. § 18031(a). Indeed, ACA proponents emphasized that "[a]ll the health insurance exchanges ... are run by states," to rebut charges that the Act was a federal "takeover." SENATE DEMOCRATIC POLICY COMM., *Fact Check: Responding to Opponents of Health Insurance Reform* (Sept. 21, 2009), http://dpc.senate.gov/reform/reform-factcheck-092109.pdf.

B. The IRS Promulgates Regulations That Nonetheless Extend the ACA's Subsidies to HHS-Established Exchanges.

Notwithstanding the ACA's text and purpose, the IRS in 2011 proposed, and in 2012 promulgated, regulations requiring the Treasury to grant subsidies for coverage purchases through *all* Exchanges—not only those established by states under § 1311 of the Act, but also those established by HHS under § 1321. 76 Fed. Reg. 50931, 50934 (Aug. 17, 2011); 77 Fed. Reg. 30,377, 30,378, 30,387 (May 23, 2012).

These regulations ("the IRS Rule") contradict the statutory text restricting subsidies to Exchanges "established by the State under section 1311." Specifically, the Rule states that subsidies shall be available to anyone "enrolled in one or more qualified health plans through an Exchange," and then adopts by cross-reference an HHS definition of "Exchange" that includes *any* Exchange, "regardless of whether the Exchange is established and operated by a State ... or by HHS." 26 C.F.R. § 1.36B-2; 45 C.F.R. § 155.20. Under the IRS Rule, federal subsidies are thus available in *all* states, even those states that failed to establish their own Exchanges. Put another way, the IRS Rule authorizes subsidies for coverage purchased through the federal Exchange colloquially known as HealthCare.Gov, not just for coverage purchased through state-established Exchanges.

Facing comments pointing out this facial inconsistency with the statute, the IRS offered only the following (77 Fed. Reg. at 30,378):

> The statutory language of section 36B and other provisions of the Affordable Care Act support the interpretation that credits are available to taxpayers who obtain coverage through a State Exchange, regional Exchange, subsidiary Exchange, and the Federally-facilitated Exchange. Moreover, the relevant legislative history does not demonstrate that Congress intended to limit the premium tax credit to State Exchanges. Accordingly, the final regulations maintain the rule in the proposed regulations because it is consistent with the language, purpose, and structure of section 36B and the Affordable Care Act as a whole.

C. 34 States Decline To Establish Their Own Exchanges, and Two Others Fail To Do So.

After the IRS announced that taxpayers would be eligible for subsidies whether or not their states established Exchanges, 34 states, including Virginia, declined to establish Exchanges. Pet.App.44a. Two states also failed to establish Exchanges in time for 2014. Pursuant to § 1321 of the ACA, HHS therefore established federal Exchanges to serve those states.

D. The IRS Rule Triggers Other ACA Mandates and Penalties.

By expanding subsidies to coverage on HHS Exchanges, the IRS Rule triggers ACA mandates and penalties for millions of individuals and thousands of employers in the states served by HealthCare.Gov. *Halbig v. Burwell*, No. 14-5018, 2014 U.S. App. LEXIS 13880, at *10-12 (D.C. Cir. July 22, 2014).

For individuals, eligibility for a subsidy triggers the Act's individual mandate penalty for many who would otherwise be exempt. The Act's penalty for violating the mandate does not apply to those "who cannot afford coverage" or who would suffer hardship if forced to buy it. *See* 26 U.S.C. § 5000A(e)(1), (5). Under regulations implementing these exemptions, an individual may obtain an advance exemption from the individual mandate penalty if the annual cost of coverage exceeds eight percent of his projected household income. *See* 45 C.F.R. § 155.605(g)(2); *see also* 26 U.S.C. § 5000A(e)(1)(A). For individuals only able to purchase coverage in the individual market, that cost is calculated as the annual premium for the cheapest insurance plan available to that person in the Exchange in that person's state, minus "the credit allowable under section 36B." 26

U.S.C. § 5000A(e)(1)(B)(ii). Thus, by purporting to make a credit "allowable" in states served by HealthCare.Gov, the IRS Rule reduces the number of people in those states exempt from the individual mandate penalty. Now ineligible for exemptions, those individuals are no longer free to forgo coverage, or to buy "catastrophic" coverage (otherwise limited to those under 30 years old, *see* ACA § 1302(e)(1)(A), (2), *codified at* 42 U.S.C. § 18022(e)(1)(A), (2)).

For employers, the availability of subsidies triggers the "assessable payments" used to enforce the Act's "employer mandate." The Act provides that large employers will be subject to such payments if they do not offer full-time employees the opportunity to enroll in affordable, employer-sponsored coverage. But the payment is only triggered if at least one employee enrolls in coverage for which "an applicable premium tax credit ... is allowed or paid." 26 U.S.C. § 4980H. Thus, if no subsidies are available in a state because that state has not established an Exchange, employers in that state may offer their employees non-compliant coverage, or no coverage at all, without being threatened with this liability. Since the IRS Rule authorizes subsidies nationwide, however, it exposes businesses in those states to the employer mandate and its assessable payments.

E. Injured Individuals and Employers Bring Suit To Challenge the IRS Rule.

Petitioners in this case are individuals residing in Virginia, which has declined to establish its own Exchanges and thus is served by HealthCare.Gov. They do not want to comply with the individual mandate, and, given their low incomes, would not be subject to penalties for failing to do so but for the IRS

Rule. The Rule renders them eligible for subsidies that would reduce the net cost of their coverage to below 8% of projected income and so disqualify them from the hardship exemption. Pet.App.47a-50a. Thus, as the district court recognized, "as a result of the IRS Rule, they will incur some financial cost because they will be forced to buy insurance or pay the [individual mandate] penalty." Pet.App.52a-53a.

In at least three other cases, other individuals and businesses injured by the IRS Rule also sued. A group of individuals and employers brought suit in the District of Columbia. *See Halbig*, 2014 U.S. App. LEXIS 13880. The State of Oklahoma filed *Pruitt v. Burwell* (No. 6:11-cv-00030, E.D. Okla.). And the State of Indiana, along with a number of school corporation employers, filed *Indiana v. IRS* (No. 1:13-cv-01612, S.D. Ind.).

F. The Courts Below Uphold the IRS Rule on the Merits, While the D.C. Circuit Finds the Rule Illegal and Orders Its Vacatur.

The district court ruled for the Government on February 18, 2014. It concluded that Petitioners had Article III standing because "their economic injury is real and traceable to the IRS Rule." Pet.App.53a. It also agreed that Petitioners could challenge the IRS Rule under the APA, and that such a challenge was ripe given the purely legal nature of the suit and the hardship that delay would cause. Pet.App.55a-60a.

On the merits, the district court recognized that Petitioners' "plain meaning interpretation of section 36B has a certain common sense appeal." Pet.App.71a. The court, nonetheless, concluded that Congress *unambiguously* intended just the contrary of that "plain meaning." The court inferred that

counter-textual intent from (i) Congress's policy goal "to ensure broad access to affordable health care for all" (Pet.App.71a); (ii) the absence of "direct support in the legislative history" confirming the plain text (Pet.App.70a); and (iii) supposed "anomalous results" under some of the Act's other provisions, were the text given its plain meaning (Pet.App.64a).

The Fourth Circuit granted Petitioners' motion to expedite (which the Government did not oppose). Dozens of *amici* weighed in at the merits stage on behalf of each side, including eight States, many Members of Congress, and industry groups such as the American Hospital Association and America's Health Insurance Plans. On July 22, 2014, the court affirmed on alternative grounds, holding the ACA to be ***ambiguous*** on whether an HHS Exchange is one "established by the State." Judge Gregory wrote the opinion, which Judges Davis and Thacker joined.

Two hours before the Fourth Circuit issued its opinion, the D.C. Circuit released its own opinion in *Halbig*, another case challenging the same IRS Rule on the same grounds. In *Halbig*, Judge Griffith authored a majority opinion on behalf of himself and Judge Randolph, over a dissent by Judge Edwards. *Halbig*, 2014 U.S. App. LEXIS 13880. The majority held that the IRS Rule was directly contrary to the unambiguous text of the ACA, and ordered that the Rule be vacated. *See id.* at *6.

The two conflicting decisions "inject uncertainty, confusion and turmoil into health insurance markets as the administration firms up plans for another open enrollment season ...." Robert Pear, *New Questions on Health Law as Courts Differ on Subsidies*, N.Y. TIMES, July 23, 2014, at A1.

REASONS FOR GRANTING THE PETITION

The reasons for granting the petition are simple and compelling. Two federal Circuits have divided over whether the IRS has authority to spend tens of billions of dollars per year to subsidize health coverage in 36 states. If the ACA means what it says, as the D.C. Circuit held, the consequences are profound: It means millions of people are ineligible for subsidies and exempt from the ACA's individual mandate penalty. It means hundreds of thousands of employers are free of the Act's employer mandate. It means a fundamental change in the health insurance market in two-thirds of the country. And it means that the IRS is illegally spending billions of taxpayer dollars every month without congressional authority. Uncertainty over this issue is simply not tenable. That is why each Circuit expedited its proceedings, and it is why this Court should grant review now and resolve the matter this Term, regardless of whether the D.C. Circuit grants en banc review of *Halbig*.

I. THE FOURTH CIRCUIT AND D.C. CIRCUIT HAVE REACHED OPPOSITE CONCLUSIONS ABOUT THE VALIDITY OF THE IRS RULE.

There is a plain conflict between two federal Courts of Appeals over the validity of the IRS Rule. The D.C. Circuit in *Halbig* ruled that an Exchange established by *HHS* is plainly not "established by the *State*," and therefore ordered the Rule vacated. The court below, however, believed that the statute was ambiguous on this question, and so upheld the Rule as a permissible exercise of agency discretion. The disagreement is clear and all of the arguments on both sides have been thoroughly aired. Only this Court can ultimately resolve the issue.

A. Although they reached contrary conclusions, the *Halbig* and *King* panels actually agreed on a number of important points.

First, both courts agreed that the plain language of § 36B—which is the specific provision authorizing subsidies—indicates that subsidies are limited to Exchanges established by states. *See Halbig*, 2014 U.S. App. LEXIS 13880, at *4 (observing that § 36B, "[o]n its face," allows subsidies only "for insurance purchased on an Exchange established by one of the fifty states or the District of Columbia"); Pet.App.16a & 18a (*King* panel op.) (conceding "common-sense appeal of [Petitioners'] argument," *i.e.*, that "the language says what it says, and that it clearly mentions state-run Exchanges under § 1311," which it would not have done had Congress actually "meant to include federally-run Exchanges"). Indeed, as the court below noted, "[i]f Congress did in fact intend to make the tax credits available to consumers on both state and federal Exchanges, it would have been easy to write in broader language, as it did in other places in the statute." Pet.App.16a-17a (citing reference elsewhere to "Exchange established under this Act").

Second, both courts rejected the Government's claims that giving § 36B its plain meaning would somehow cause "anomalies" in other parts of the Act. The Fourth Circuit below was "unpersuaded" as to the alleged anomalies. Pet.App.22a. "Both parties offer reasonable arguments and counterarguments that make discerning Congress's intent [from these provisions] difficult." *Id.* Additionally, the panel recognized that this Court just admonished courts to avoid "revising" legislation "out of an effort to avoid 'apparent anomal[ies]' within a statute." *Id.* (quoting

Michigan v. Bay Mills Indian Cmty., 134 S. Ct. 2024, 2033 (2014)). As such, it "decline[d] to accept [the Government's] arguments as dispositive of Congress's intent." Pet.App.22a. *Halbig*, too, found that the supposed anomalies did not reach the "'high threshold' of unreasonableness" necessary to allow a court to "conclude that a statute does not mean what it says." 2014 U.S. App. LEXIS 13880, at *32-33. *Accord Exxon Mobil Corp. v. Allapattah Servs., Inc.*, 545 U.S. 546, 565 (2005) ("[I]t is up to Congress rather than the courts to fix" even "unintentional drafting gap[s]."). Indeed, as to one of the supposed anomalies, *Halbig* determined that it "creates no difficulty, let alone absurdity"; as to the other, the results "seem sensible, not absurd." 2014 U.S. App. LEXIS 13880, at *39, *42. Accordingly, "[n]othing about the imperative to read section 36B in harmony with the rest of the ACA requires interpreting 'established by the State' to mean anything other than what it plainly says." *Id.* at *43.

Third, both courts agreed that nothing in the Act's legislative history contradicted § 36B's text. As the panel below noted, the history is "not particularly illuminating on the issue." Pet.App.22a. *Accord Halbig*, 2014 U.S. App. LEXIS 13880, at *47 ("[T]he scant legislative history sheds little light on the precise question of the availability of subsidies on federal Exchanges."). Congress seemed to assume that subsidies would be available nationwide, but "it is possible that such statements were made under the assumption that every state would in fact establish its own Exchange." Pet.App.23a-24a. After all, "Congress did not expect the states to turn down federal funds and fail to create and run their own Exchanges." *Id.* As *Halbig* similarly observed, the

assumption of nationwide subsidies is "as consistent with an expectation that all states would cooperate (*i.e.*, establish their own Exchanges) as with an understanding that subsidies would be available on federal Exchanges as well." 2014 U.S. App. LEXIS 13880, at *47-48. Of course, the legislative history did not itself prove that Congress meant what it said in § 36B, but "clear text speaks for itself and requires no 'amen' in the historical record." *Id.* at *46. *Accord Harrison v. PPG Indus., Inc.*, 446 U.S. 578, 592 (1980) ("[I]t would be a strange canon of statutory construction that would require Congress to state in committee reports or elsewhere in its deliberations that which is obvious on the face of a statute.").

Fourth, both courts recognized that there was a "plausible" reason why Congress might have wanted to condition subsidies on the establishment of state Exchanges—an account that would "comport with a literal reading" of § 36B. Pet.App.25a. Namely, Congress could quite reasonably have intended subsidies as an *incentive*, so that states—not the federal government—would bear this burden. *Id.*; *accord Halbig*, 2014 U.S. App. LEXIS 13880, at *52 n.11. After all, "Congress has conditioned federal benefits on state cooperation in other contexts," including in the ACA's own Medicaid expansion, and a Senate committee "proposed a bill that specifically contemplated penalizing states that refused to participate in establishing" Exchanges. *Id.* at *48-49, *52 n.11; *see also* S. 1679, § 3104(a), (d), 111th Cong. (2009). Since it seemed clear that "no state would refuse so good an offer," *Halbig*, 2014 U.S. App. LEXIS 13880, at *52 n.11, using subsidies as an incentive would allow Congress to achieve *both* goals: state-run Exchanges *and* subsidies nationwide.

B. Although *King* and *Halbig* thus both agreed that (i) § 36B limits subsidies to Exchanges that are established by states; (ii) such a reading would not create any anomalous or absurd results in the rest of the statute; (iii) the legislative history did not refute this plain reading of the law; and (iv) Congress had a very plausible basis for meaning precisely what it said, the two courts nonetheless diverged on whether the IRS Rule was legally valid.

The panel below, for its part, rested its result on the notion that, although § 36B limits subsidies to coverage purchased through Exchanges "established by the State," other provisions of the ACA create ambiguity as to whether an Exchange established by HHS is somehow actually "established by the State." Pet.App.17a-18a. In particular, the court reasoned that while § 1311 directs states to create Exchanges, § 1321 clarifies that states may decline to do so—in which case, HHS shall establish "*such* Exchange within the State." ACA § 1321(c)(1), *codified at* 42 U.S.C. § 18041(c)(1) (emphasis added). According to the panel, this may imply a legal fiction under which HHS "acts on behalf of the state when it establishes its own Exchange," which therefore, in some sense, could be described as "established by the State." Pet.App.18a. While the court admitted this does not accord as closely with a "literal reading" of the Act, it found it sufficient to create ambiguity. *Id.*

To resolve this supposed ambiguity, the court applied deference. It reasoned that "the importance of the tax credits to the overall statutory scheme" makes it "reasonable to assume that Congress created the ambiguity" intentionally, so that the IRS could resolve it. Pet.App.27a n.4. The court rejected

Petitioners' argument that a venerable canon of construction—tax credits must be expressed in "clear and unambiguous language," *Yazoo & Miss. Valley R.R. Co. v. Thomas*, 132 U.S. 174, 186 (1889)—had displaced *Chevron* as the way to resolve ambiguity in § 36B. Pet.App.32a-33a. The court further held that deference to the IRS was proper even though the "ambiguity" arose in § 1321 of the Act, administered by *HHS*—not in the Internal Revenue Code. Pet.App.32a. Ultimately, because the Rule advanced "the broad policy goals of the Act," the panel upheld it under *Chevron* Step Two. Pet.App.27a.

By contrast, the *Halbig* panel squarely rejected the argument that § 1321 of the ACA, and use of the word "such," created relevant "equivalence" between state and HHS Exchanges. *Halbig*, 2014 U.S. App. LEXIS 13880, at *22-25. As the court recognized, use of the word "such" directs HHS to establish the same *type* of Exchange as "a state would have established had it elected to do so," which would not otherwise have been clear. *Id.* at *23. Critically, though, that could not change the fact that subsidies under § 36B turn on "*who* established" the Exchange; a federal Exchange is not "established *by the State*." *Id.* at *24 (emphases added). It is established when a state *refuses* to establish an Exchange. Further, § 1321 does not expresly *deem* HHS Exchanges to be "established by the State"—a "significant" omission given that Congress did expressly provide that a U.S. territory "shall be treated as a State" if it elects to establish an Exchange. *Id.* (quoting 42 U.S.C. § 18043(a)). *Halbig* thus found "no textual basis—in sections 1311 and 1321 or elsewhere—for concluding that a federally-established Exchange is, in fact or legal fiction, established by a state." *Id.* at *31.

Given that conclusion, *Halbig* refused to "ignore the best evidence of Congress's intent—the text of section 36B—in favor of assumptions about the risks that Congress would or would not tolerate." *Id.* at *59. It therefore vacated the Rule as contrary to the unambiguous statutory text. After all, "an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate." *Util. Air Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2446 (2014). "And," the court continued, "neither may we." *Halbig*, 2014 U.S. App. LEXIS 13880, at *59.

C. Thus, while the Fourth and D.C. Circuits agreed on a great number of points, they diverged on the critical issue: Is there ambiguity over whether an Exchange established by the federal government under § 1321 is somehow "established by the State under section 1311"? And that divergence led one court to vacate the Rule and the other to uphold it.

Notably, this Circuit split is especially troubling given uncertainty over how the competing rulings would apply even in the Fourth Circuit's territorial jurisdiction. On one hand, the decision below would ordinarily be thought to resolve the validity of subsidies within the states comprising the Fourth Circuit: Virginia, Maryland, North Carolina, South Carolina, and West Virginia. Yet, on the other hand, one of the *Halbig* plaintiffs resides in West Virginia. Further, the D.C. Circuit has long held that when it vacates a rule under the APA, such a decision has "nationwide" effect. *Nat'l Mining Ass'n v. U.S. Army Corps of Eng'rs*, 145 F.3d 1399, 1409-10 (D.C. Cir. 1998). This division therefore not only has the usual effect of regional disuniformity, but also creates a special sort of nationwide confusion and conflict.

II. PROFOUND CONSEQUENCES OF DELAY MEAN THAT THIS COURT'S DEFINITIVE RESOLUTION IS URGENTLY NEEDED.

The monumental significance of this legal issue requires this Court's immediate, urgent attention. The two conflicting Circuit decisions have created intolerable uncertainty over a major component of the ACA's implementation. If this Court ultimately agrees with the D.C. Circuit that the IRS Rule is contrary to law, as is highly likely, the consequences for individuals, employers, insurers, states, and federal spending will be vast—and the longer that the lawless IRS Rule is in effect, the greater the upheaval when it is ultimately vacated. As both Courts of Appeals recognized by expediting their own proceedings, it is in everyone's interest to obtain final resolution as soon as possible. Only this Court can provide that resolution, and this petition is the only vehicle by which it could do so this Term.

A. Given the self-evident enormous importance of the IRS Rule to the *ongoing* implementation of the ACA, to the *immediate* economic decisions of millions of Americans and thousands of businesses, and to the *currently flowing* billions of dollars in expenditures that the D.C. Circuit ruled illegal, the need for this Court's review is plainly and uniquely urgent.

As to *individuals*, the *Halbig* court recognized that its ruling would have "significant consequences" for the "millions of individuals receiving tax credits through federal Exchanges." *Halbig*, 2014 U.S. App. LEXIS 13880, at *61-62. Estimates show that nearly 5 million individuals have been receiving subsidies through HHS Exchanges. *See* Pear, *New Questions on Health Law*, *supra* (noting that "more than 4.5

million people ... were found eligible for subsidized insurance in the federal exchange"). In the wake of the conflicting Circuit decisions, these millions of Americans who have been relying on subsidies do not know whether they can continue to count on them or need to make other arrangements for health care. Importantly, these consequences become more severe the longer it takes to finally vacate the IRS Rule. Indeed, under the ACA as written, if the Treasury improperly pays for part of an individual's premium, but it later turns out that the individual is not entitled to a subsidy, it is the low- or middle-income American who may be on the hook to repay the improper payments (subject to certain caps). *See* 26 U.S.C. § 36B(f)(2). Every month that subsidies are paid on the authority of the IRS Rule, its millions of beneficiaries thus not only detrimentally rely on its validity to make important economic decisions, but are potentially incurring thousands of dollars of potential debt—owed to the IRS as back taxes. This is grossly unfair, and only prompt resolution of the legal dispute can curtail that unfairness.

Further, millions of Americans are in the same position as Petitioners here—namely, subject to the Act's individual mandate only if the IRS Rule stands. In light of the conflicting rulings, these individuals have no idea whether they are required to purchase comprehensive health coverage (which they may well not want) or are free instead to forgo coverage or buy only catastrophic coverage. Nor do they know if they will be subject to fines if they fail to purchase ACA-compliant coverage. *Cf. Abbott Labs. v. Gardner*, 387 U.S. 136, 152 (1967) (citing "dilemma" of either "comply[ing] ... and incur[ring] the costs" of doing so or violating law "and risk[ing]" penalties if challenge

fails). This uncertainty, affecting the economic decisions of an untold number of Americans, can be resolved only through this Court's immediate review.

As to *employers*, the ACA's employer mandate is scheduled to take effect January 1, 2015 (after delays imposed unilaterally by the Administration). Under that provision, many employers must either sponsor affordable coverage for their full-time employees or else pay large penalties. But penalties are triggered only if "at least one full-time employee enrolls in a health plan and qualifies for a subsidy" under the Act. *Burwell v. Hobby Lobby Stores, Inc.*, Nos. 13-354, 13-356, 2014 U.S. LEXIS 4505, at *22-23 (2014). Thus, in the 36 states served by HealthCare.Gov, employers will be exposed to these penalties only if the IRS Rule is upheld. *See* Dan Eaton, *Who Gets the Last Word on Obamacare?*, CNBC.com, July 23, 2014 ("The answer matters to the estimated 250,000 employers in the 36 states with federally facilitated exchanges ...."). Again, therefore, in light of the conflicting Circuit decisions, hundreds of thousands of businesses in three dozen states have no idea whether they are required to provide ACA-compliant coverage to employees next year. That uncertainty also threatens many *employees*, because employers worried by potential penalties may lay off workers or reduce their hours to evade the employer mandate. *See, e.g.*, Robert Pear, *Public Sector Capping Part-Time Hours to Skirt Health Care Law*, N.Y. TIMES, Feb. 21, 2014, at A12. This damaging uncertainty can be lifted only by this Court's final review.

As to *insurers*, the validity *vel non* of the IRS Rule is crucial to their budgeting, planning, and rate-setting for future coverage. If the Rule is invalid as

the D.C. Circuit held, that will have a substantial effect on the makeup and revenue of the insurance pool going forward. Pear, *New Questions on Health Law*, *supra* ("The contradictory rulings ... could inject uncertainty, confusion and turmoil into health insurance markets ...."). Delay in resolving the matter is thus likely to impose even heavier logistical and financial stresses on insurance markets. *Cf. Halbig*, 2014 U.S. App. LEXIS 13880, at *61-62 (acknowledging decision's "significant consequences" for "health insurance markets more broadly").

As to *states*, the resolution of this issue will have a dramatic impact on incentives regarding whether to establish their own Exchanges prospectively (or, as some states are now considering, shutting down their Exchanges in favor of HealthCare.Gov). States are likely to act very differently if establishing an Exchange will determine whether state residents are entitled to billions in tax credits. *See, e.g.*, Louise Radnofsky, *States Try To Protect Health Exchanges from Court Ruling*, WALL ST. J., July 25, 2014 ("A leading proponent of a fully state-run exchange [in Illinois] said he believed legislators would back his position if the D.C. panel's decision is upheld."). Indeed, as a group of state legislator *amici* told the court below, had they known "that their constituents would lose access to these tax credits unless the State established its own Exchange, they would have vigorously advocated for a state-run Exchange citing this potential consequence." Amici Br. of Members of Cong. et al. 5. Immediate review by this Court would allow states more time to make this decision with a full understanding of its legal consequences, whereas delay would potentially preclude them from timely "opting-in" to the ACA for subsequent years.

Finally, and perhaps most importantly, billions of taxpayer dollars are *right now* streaming out of the federal Treasury under the authority of the IRS Rule. (The Government estimated below that the cost of the subsidies would eventually amount to approximately $150 billion per year. Govt. C.A. Br. 5.) These funds will continue to be spent *every month* until vacatur of the IRS Rule takes effect. *See* Editorial, *Fast-Tracking ObamaCare to the Supreme Court*, WALL ST. J., July 23, 2014 ("The subsidies will continue to flow as long as the litigation is ongoing, which means that tens of billions of dollars are being distributed illegally."). Because "the protection of the public fisc is a matter that is of interest to every citizen," *Brock v. Pierce Cnty.*, 476 U.S. 253, 262 (1986), there is thus an enormous public interest in ensuring that these funds are not illegally disbursed. The longer this litigation drags on, the more money is unlawfully spent without congressional approval—a very serious matter indeed. *Cf.* 31 U.S.C. § 1341 (criminalizing payments from U.S. Treasury not "authorized by law"). This is yet another powerful reason why this Court should strive to provide a definitive resolution as quickly as possible.

B. Both of the Circuits to have considered this issue recognized the important public interest served by prompt disposition. The D.C. Circuit granted the *Halbig* plaintiffs' motion to expedite—and, indeed, ordered expedition even more drastic than requested, allowing them only seven days to file their opening brief. After that ruling, the Government chose not to oppose Petitioners' motion asking the Fourth Circuit to similarly expedite this case—which that court also granted.

C. This petition is the only vehicle that would allow this Court to resolve this matter within the October 2014 Term. The cases filed by Oklahoma and Indiana have not yet been decided by district courts, and the Government has announced its intent to seek *en banc* review of *Halbig*, rather than proceed directly to this Court as it did when the Eleventh Circuit invalidated the individual mandate in 2011. *DOJ To Appeal 'Incorrect' Halbig Ruling*, POLITICO, July 22, 2014 ("The government will seek an en banc review from the full D.C. court of appeals, a Justice official said."). If the D.C. Circuit grants rehearing, *Halbig* would not reach the Court this Term.

Importantly, even *en banc* reversal of *Halbig* would by no means reduce the pressing need for this Court's review. The issue is obviously exceptionally important, and the *Halbig* panel opinion proved that Petitioners' challenge is sufficiently compelling to require the Court's attention. *Accord* Tom Goldstein, *The Fate of the Obamacare Subsidies in the Supreme Court*, SCOTUSBLOG.COM, July 23, 2014 ("But even if [*en banc* reversal] happens, the case seems too close and too important for the Supreme Court to pass it up."). Untenable uncertainty will persist until this Court supplies a definitive answer, especially since other challenges are already working their way to the Seventh and Tenth Circuits, and challenges in other Circuits are very likely. Indeed, given the IRS Rule's irreconcilable conflict with the ACA's plain language, it is quite probable that the Rule will be invalidated at some point by another court. It is far better for this Court to resolve this question now, to both preclude further detrimental reliance and to eliminate the Sword of Damocles that will inevitably hang over the IRS Rule otherwise.

III. THE FOURTH CIRCUIT PLAINLY ERRED BY FINDING AMBIGUITY IN § 36B AND BY DEFERRING TO THE IRS TO RESOLVE IT.

If it were clear that *Halbig* was plainly wrong in construing § 36B as it did, perhaps this Court could safely assume that the *en banc* court would correct its error and no other court would follow its lead. But, to the contrary, it is the court below that plainly erred, both in finding ambiguity despite clear text, and by deferring to the IRS as a means to resolve that supposed ambiguity. Those errors make this Court's intervention all the more inevitable.

A. As explained, the Fourth Circuit did not accept the Government's arguments that § 36B's plain text would create absurd results, or that the legislative history refuted that text, or that Congress could not possibly have meant to condition subsidies on state Exchanges. Rather, it acknowledged the "common-sense appeal of the plaintiffs' argument" and admitted that it was "at least plausible" that Congress meant what it said in § 36B. Pet.App.18a, 25a. The panel nonetheless found the Act ambiguous by claiming that the provision directing HHS to establish Exchanges in states that failed to do so could be read as creating a legal fiction under which even Exchanges established by HHS are "established by the State." That reading is obviously wrong.

First, ambiguity exists for *Chevron* purposes only if it remains after the court "employ[s] traditional tools of statutory construction." *Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 843 n.9 (1984). Yet every canon of construction confirms that "established by the State" *cannot* be read to include *all* Exchanges, even those created by HHS.

On such a reading, the modifier "established by the State" in § 36B would serve no purpose, violating the "cardinal principle" that "no clause ... shall be superfluous, void, or insignificant." *Duncan v. Walker*, 533 U.S. 167, 174 (2001). More to the point, the problem here is not *redundancy*, but that § 36B specifically answers the precise question at issue; on the Government's view, Congress added superfluous words that *directly contradict* its own intent. Moreover, Congress elsewhere used the broader phrase "Exchange established under this Act," Pet.App.17a, which clearly includes HHS-established Exchanges. Giving that broader meaning to § 36B's narrower words violates the canon that "differing language" in "two subsections" of a statute should not be given "the same meaning." *Russello v. United States*, 464 U.S. 16, 23 (1983). Further, § 36B itself elsewhere refers expressly to *both* state- and HHS-established Exchanges distinctly, proving that the Act does not equate them: A subsection of § 36B requiring information reporting by Exchanges applies to an "Exchange under Section 1311(f)(3) or 1321(c)." 26 U.S.C. § 36B(f)(3). This proves that when Congress wanted to encompass both state- and HHS-established Exchanges, it "knew how to do so." *Custis v. United States*, 511 U.S. 485, 492 (1994).

Second, the panel's notion that HHS acts *on the state's behalf* in establishing a fallback Exchange is neither correct nor relevant. The ACA does *not* say that HHS should establish Exchanges "on behalf of" declining states. It says that HHS should establish Exchanges "within" them. ACA § 1321(c), *codified at* 42 U.S.C. § 18041(c). That is language of *geography*, not *agency*. And even if the Act had said that HHS should act "on the State's behalf," that Exchange

would still be established *by HHS for the state*, not *by the state*. Finally, the crucial premise allowing HHS to act in the first place is the state's *failure* to. HHS thus cannot be acting "on behalf of the state," Pet.App.18a, because the state has clearly decided that it does *not* want to establish an Exchange. HHS is acting *instead of* the state.

Third, because § 1321 describes only when and how HHS Exchanges come into *existence*, but says nothing about whether they may grant subsidies, Congress could have extended subsidies to those Exchanges only by "deeming" Exchanges established by HHS to be "established by the State." Congress did just that for Exchanges established by *territories*: Section 1323 provides that if a territory creates an Exchange, it "shall be treated as a State" for such purposes. 42 U.S.C. § 18043(a)(1). Likewise, a House version of the ACA—which created a national Exchange but allowed states to choose to run their own—said that, if a state did so, "any references in this subtitle to the Health Insurance Exchange ... shall be deemed a reference to the State-based Health Insurance Exchange." H.R. 3962, § 308(e), 111th Cong. (2009). No equivalent language about HHS Exchanges appears in the enacted ACA; as noted, § 1321's language comes nowhere close.

The panel below apparently believed, incorrectly, that "Congress defined 'Exchange' as an Exchange established by the state," supposedly bolstering the claim that § 1321 somehow commands the literally nonsensical: "state-established" Exchanges established by HHS. Pet.App.18a. In fact, the Act defines "Exchange" as "an American Health Benefit Exchange established under section 1311." ACA

§ 1563(b)(21), *codified at* 42 U.S.C. § 300gg-91(d)(21). At most, that definition could sow doubt over the metaphysical question whether Exchanges created by HHS *pursuant to* § 1321 are created "under" that section or "under" § 1311. Either way, however, they are established *by HHS*, not the state. Indeed, this potential confusion is presumably why § 36B specifically limits the subsidies to Exchanges "established *by the State* under section 1311."

Beyond the Act's global definition of "Exchange," the panel also cited § 1311(d)(1) of the ACA, which explains that an Exchange "shall be a governmental agency or nonprofit entity that is established by a State." 42 U.S.C. § 18031(d)(1). The panel thought that this "narrow[s] the definition of 'Exchange' to encompass only state-created Exchanges," and that a narrow focus on "state-created Exchanges" somehow *supports* inclusion of "HHS-created Exchanges" in § 36B. Pet.App.17a. Even the Government did not make that argument—for good reason: Section 1311 is the provision directing *states* to establish Exchanges. Section 1311(d)(1) simply specifies that states may do so through a state agency or nonprofit. This is not a "definition" of "Exchange," much less one that somehow transmogrifies HHS Exchanges into Exchanges that are "established by the State." *See Halbig*, 2014 U.S. App. LEXIS 13880, at *25-30.

B. The panel below erred again by deferring to the IRS Rule to resolve this supposed "ambiguity." For four distinct reasons, deference is inapplicable.

First, for the reasons discussed, the Act's text is unambiguous. Where Congress has "unambiguously expressed [its] intent" in the law, "that is the end of the matter." *Chevron*, 467 U.S. at 842-43.

Second, as this Court just reiterated, "[w]e expect Congress to speak clearly if it wishes to assign to an agency decisions of vast 'economic and political significance.'" *Util. Air*, 134 S. Ct. at 2444 (quoting *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 160 (2000)). Few decisions will have greater economic or political significance than one triggering hundreds of billions of dollars per year in spending and expanding major components of the ACA to more than two-thirds of the states. The panel below recognized as much, but backwardly argued that "the importance of the tax credits" makes it *more* "reasonable to assume that Congress created the ambiguity." Pet.App.27a n.4. As this Court's cases make clear, however, the opposite is true: It is inherently implausible that Congress wanted *the IRS* to decide on the expenditure of this huge sum of money, or on how far the ACA's mandates should extend. The IRS Rule is thus a major policy in search of ambiguity—not a mere detail that Congress intended the IRS to fill. Indeed, that is why § 36B "directly spok[e] to the precise question" at issue, rather than leave the answer ambiguous. *Chevron*, 467 U.S. at 842.

Third, ambiguity may be resolved by an agency only if it remains after "employing traditional tools of statutory construction," including presumptions that resolve ambiguity. *Id.* at 843 n.9. Thus, where established canons require a clear statement of Congress's intent to infer certain results, an agency cannot impose those results through ambiguous text. *See, e.g.*, *EEOC v. Arabian Am. Oil Co.*, 499 U.S. 244, 250, 258 (1991) (deference cannot "overcome the presumption against extraterritorial application"); *INS v. St. Cyr*, 533 U.S. 289, 320 n.45 (2001) ("[A]

statute that is ambiguous with respect to retroactive application is construed ... to be unambiguously prospective," so that "there is, for *Chevron* purposes, no ambiguity."); *Muscogee (Creek) Nation v. Hodel*, 851 F.2d 1439, 1444-45 & n.8 (D.C. Cir. 1988) (refusing to defer because if law "can reasonably be construed" in Indian tribe's favor, "it *must* be").

To protect *Congress's* exclusive authority over the federal purse, this Court has long held that tax credits must be expressed in "clear and unambiguous language" in statutes. *Yazoo*, 132 U.S. at 186. Such benefits "must rest ... on more than a doubt or ambiguity." *United States v. Stewart*, 311 U.S. 60, 71 (1940). If "doubts are nicely balanced," that defeats the claimed tax benefit. *Trotter v. Tennessee*, 290 U.S. 354, 356 (1933). In light of this venerable rule allowing money to be drawn from the Treasury only when the congressional custodian of the federal purse has unambiguously authorized it, deference cannot apply to the proper interpretation of § 36B. The IRS cannot by regulation extend or expand the credits by resting on "doubt or ambiguity" in the ACA. *Stewart*, 311 U.S. at 71.

The court below contended, based on *Mayo Foundation for Medical Education and Research v. United States*, 131 S. Ct. 704 (2011), that this canon does not displace *Chevron* deference. Pet.App.33a. Actually, *Mayo* expressly *confirmed* that tax exemptions must be "construed narrowly." *Id.* at 715. Because the Government construed the exemption narrowly there, *Chevron* and the tax-credit canon reinforced one another. Here, however, the canon has the effect of eliminating any ambiguity, giving *Chevron* deference no room to operate.

Fourth, there is no basis for *Chevron* deference to the IRS, because § 36B—the only relevant provision that falls within the Internal Revenue Code—is not ambiguous on its own. Pet.App.16a-17a. Rather, it is only the distinct ACA provisions allowing for state and federal Exchanges that purportedly make it plausible to construe the Act as extending subsidies to the latter. *See* Pet.App.18a. Yet those provisions are codified in a chapter of *Title 42* of the U.S. Code—the domain of *HHS*, not the IRS. *See* 42 U.S.C. §§ 18031, 18041. Thus, the fact that the IRS has "authority to resolve ambiguities in 26 U.S.C. § 36B," Pet.App.32a, does not save the IRS Rule—because § 36B is not the arguably ambiguous provision. *Cf. Cheney R.R. Co. v. R.R. Ret. Bd.*, 50 F.3d 1071, 1073-74 (D.C. Cir. 1995) (no deference to agency where issue "turn[ed] on the interpretation" of laws "not the Board's governing statutes").

C. Although the panel did not rely on them, Judge Davis's concurrence (and Judge Edwards's *Halbig* dissent) made other arguments for why HHS Exchanges are supposedly "established by the State." These turn statutory interpretation on its head.

First, both judges emphasized the need to read statutory language "in context," as if that somehow supports the IRS Rule. *See* Pet.App.36a; *Halbig*, 2014 U.S. App. LEXIS 13880, at *65 (Edwards, J., dissenting). To the contrary, all that a "contextual" reading demonstrates is that § 36B is the *only* provision that addresses subsidies. Yet that is the provision these judges ignore. They cite § 1321, but the fact that the Act *envisions* HHS Exchanges when states default cannot suggest that the subsidy provision's reference to "Exchange established by the

State" somehow connotes an HHS Exchange. To the contrary, precisely *because* the ACA calls for two distinct entities to establish Exchanges, the phrase "Exchange established by the State" cannot include one established by HHS. And reading the statute "as a whole" *confirms* that Congress knew how to deem non-state entities to be states when it intended to. *See* p.26, *supra* (U.S. territories).

Second, both judges objected that if Congress had sought to limit subsidies to state Exchanges, it would not have done so by "tinkering with the formula" for how to compute the subsidy's value. Pet.App.39a; *see also Halbig*, 2014 U.S. App. LEXIS 13880, at *78 (Edwards, J., dissenting). But the formula is the *only* provision that defines the transactions eligible for subsidies. Even the Government agrees that only coverage purchased through an *Exchange* can be subsidized; that limit is found only in the same clause that these judges object is too obscure to take seriously. Moreover, it is not at all unusual for Congress to put conditions on eligibility for tax credits into the formula for calculating them—even if the conditions require states to take action to render their citizens eligible. *See, e.g.*, 26 U.S.C. § 35(a), (b), (e); *Halbig*, 2014 U.S. App. LEXIS 13880, at *27 n.4.

Third, lacking any serious textual argument, Judges Davis and Edwards fall back on the supposed broad "purposes" of the ACA. Subsidies are "critical" to proper operation of the Act, because they make coverage more affordable, Pet.App.40a, and are purportedly intended to counteract upward pressure on premiums caused by the Act's regulatory provisions, *Halbig*, 2014 U.S. App. LEXIS 13880, at *80-93 (Edwards, J., dissenting). Yet, as this Court

has often repeated, "vague notions of a statute's 'basic purpose' are ... inadequate to overcome the words of its text." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 261 (1993). Particularly with a law as complex as the ACA, "it frustrates rather than effectuates legislative intent simplistically to assume that *whatever* furthers the statute's primary objective must be the law." *Rodriguez v. United States*, 480 U.S. 522, 526 (1987) (per curiam).

In any case, as both the *King* and *Halbig* panels agreed, it is entirely plausible that Congress used subsidies as an incentive to induce states to establish their own Exchanges. Indeed, Congress in the ACA did the same thing by conditioning Medicaid grants on states' expansion of their Medicaid programs. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2601 (2012). Only by promising states the "quid" of subsidies without demanding the "quo" of state Exchanges did the IRS Rule eliminate the incentive, depriving Congress of the opportunity to satisfy *both* of its policy "purposes"—universal subsidies *and* state-established Exchanges.

Judges Davis and Edwards scoff that there is no support for this theory. *See* Pet.App.37a; *Halbig*, 2014 U.S. App. LEXIS 13880, at *101 (Edwards, J., dissenting). But the support is the clear statutory *text*, which would govern even in the face of *contradictory* legislative history. *Conn. Nat'l Bank v. Germain*, 503 U.S. 249, 254 (1992). It is thus outrageous to suggest that legislative history must *confirm* plain text that is consistent with plausible, non-absurd purposes. "[C]lear text speaks for itself and requires no 'amen' in the historical record." *Halbig*, 2014 U.S. App. LEXIS 13880, at *46.

Moreover, it is simply false that the "incentive" purpose is "made up out of whole cloth." *Halbig*, 2014 U.S. App. LEXIS 13880, at *67 (Edwards, J., dissenting). The subsidy incentive mirrors the ACA's own Medicaid incentive. Also, a Senate committee version of the ACA conditioned subsidies on the state's adoption of, *inter alia*, "insurance reform provisions." S. 1679, § 3104, 111th Cong. (2009). Moreover, the incentive was well understood by, among others, Prof. Jonathan Gruber, a leading architect of the ACA who helped "draft the specifics of the legislation," Catherine Rampell, *Mr. Health Care Mandate*, N.Y. TIMES, Mar. 29, 2012, at B1, and later explained that "if you're a state and you don't set up an Exchange, that means your citizens don't get their tax credits." Robert Pear & Peter Baker, *Ex-Aide's Statements in 2012 Clash with Health Act Stance*, N.Y. TIMES, July 26, 2014, at A16.

CONCLUSION

The petition for a writ of certiorari should be granted.

JULY 2014

Respectfully submitted,

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APPENDIX

APPENDIX A

No.14-1158

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

DAVID KING; DOUGLAS HURST; BRENDA LEVY; ROSE LUCK,

Plaintiffs – Appellants,

v.

SYLVIA MATTHEWS BURWELL, in her official capacity as U.S. Secretary of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES; JACOB LEW, in his official capacity as U.S. Secretary of the Treasury; UNITED STATES DEPARTMENT OF THE TREASURY; INTERNAL REVENUE SERVICE; JOHN KOSKINEN, in his official capacity as Commissioner of Internal Revenue,

Defendants – Appellees,

SENATOR JOHN CORNYN; SENATOR TED CRUZ; SENATOR ORRIN HATCH; SENATOR MIKE LEE; SENATOR ROB PORTMAN; SENATOR MARCO RUBIO; CONGRESSMAN DARRELL ISSA; PACIFIC RESEARCH INSTITUTE; THE CATO INSTITUTE; THE AMERICAN CIVIL RIGHTS UNION; JONATHAN H. ADLER; MICHAEL F. CANNON; STATE OF OKLAHOMA; STATE OF ALABAMA;

STATE OF GEORGIA; STATE OF WEST VIRGINIA; STATE OF NEBRASKA; STATE OF SOUTH CAROLINA; CONSUMERS' RESEARCH; STATE OF KANSAS; THE GALEN INSTITUTE,

Amici Supporting Appellants,

COMMONWEALTH OF VIRGINIA; AMERICA'S HEALTH INSURANCE PLANS; AMERICAN CANCER SOCIETY; AMERICAN CANCER SOCIETY CANCER ACTION NETWORK; AMERICAN DIABETES ASSOCIATION; AMERICAN HEART ASSOCIATION; PUBLIC HEALTH DEANS, CHAIRS, AND FACULTY; MEMBERS OF CONGRESS AND STATE LEGISLATURES; AMERICAN HOSPITAL ASSOCIATION; ECONOMIC SCHOLARS; FAMILIES USA; AARP; NATIONAL HEALTH LAW PROGRAM,

Amici Supporting Appellees.

Appeal from the United States District Court for the Eastern District of Virginia, at Richmond. James R. Spencer, Senior District Judge. (3:13-cv-00630-JRS)

Argued: May 14, 2014 Decided: July 22, 2014

Before GREGORY and THACKER, Circuit Judges, and DAVIS, Senior Circuit Judge.

Affirmed by published opinion. Judge Gregory wrote the opinion, in which Judge Thacker and Senior Judge Davis joined. Judge Davis wrote a concurring opinion.

ARGUED: Michael Anthony Carvin, JONES DAY, Washington, D.C., for Appellants. Stuart F Delery, UNITED STATES DEPARTMENT OF JUSTICE, Washington, D.C., for Appellees. Stuart Alan Raphael, OFFICE OF THE ATTORNEY GENERAL OF VIRGINIA, Richmond, Virginia, for Amicus Commonwealth of Virginia. **ON BRIEF**: Yaakov M. Roth, Jonathan Berry, JONES DAY, Washington, D.C., for Appellants. Dana J. Boente, United States Attorney, OFFICE OF THE UNITED STATES ATTORNEY, Alexandria, Virginia; Beth S. Brinkmann, Deputy Assistant Attorney General, Mark B. Stern, Alisa B. Klein, Civil Division, UNITED STATES DEPARTMENT OF JUSTICE, Washington, D.C., for Appellees. Michael E. Rosman, CENTER FOR INDIVIDUAL RIGHTS, Washington, D.C.; Carrie Severino, THE JUDICIAL EDUCATION PROJECT, Washington, D.C.; Charles J. Cooper, David H. Thompson, Howard C. Nielson, Jr., Brian W. Barnes, COOPER & KIRK, PLLC, for Amici Senator John Cornyn, Senator Ted Cruz, Senator Orrin Hatch, Senator Mike Lee, Senator Rob Portman, Senator Marco Rubio, and Congressman Darrell Issa. C. Dean McGrath, Jr., MCGRATH & ASSOCIATES, Washington, D.C.; Ilya Shapiro, CATO INSTITUTE, Washington, D.C.; Bert W. Rein, William S. Consovoy, J. Michael Connolly, WILEY REIN LLP, Washington, D.C., for Amici Pacific Research Institute, The Cato Institute, and The American Civil Rights Union. Andrew M. Grossman, BAKER HOSTETLER, Washington, D.C., for Amici Jonathan H. Adler and Michael F. Cannon. E. Scott Pruitt, Attorney General, Patrick R. Wyrick, Solicitor General, OFFICE OF THE ATTORNEY GENERAL

OF OKLAHOMA, Oklahoma City, Oklahoma; Luther Strange, Attorney General, OFFICE OF THE ATTORNEY GENERAL OF ALABAMA, Montgomery, Alabama; Sam Olens, Attorney General, OFFICE OF THE ATTORNEY GENERAL OF GEORGIA, Atlanta, Georgia; Patrick Morrisey, Attorney General, OFFICE OF THE ATTORNEY GENERAL OF WEST VIRGINIA, Charleston, West Virginia; Jon Bruning, Attorney General, Katie Spohn, Deputy Attorney General, OFFICE OF THE ATTORNEY GENERAL OF NEBRASKA, Lincoln, Nebraska; Alan Wilson, Attorney General, OFFICE OF THE ATTORNEY GENERAL OF SOUTH CAROLINA, Columbia, South Carolina, for Amici State of Oklahoma, State of Alabama, State of Georgia, State of West Virginia, State of Nebraska, and State of South Carolina. Rebecca A. Beynon, KELLOGG, HUBER, HANSEN, TODD, EVANS & FIGEL, P.L.L.C., Washington, D.C., for Amicus Consumers' Research. Derek Schmidt, Attorney General, Jeffrey A. Chanay, Deputy Attorney General, Stephen R. McAllister, Solicitor General, Bryan C. Clark, Assistant Solicitor General, OFFICE OF THE ATTORNEY GENERAL OF KANSAS, Topeka, Kansas; Jon Bruning, Attorney General, OFFICE OF THE ATTORNEY GENERAL OF NEBRASKA, Lincoln, Nebraska, for Amici State of Kansas and State of Nebraska. C. Boyden Gray, Adam J. White, Adam R.F Gustafson, BOYDEN GRAY & ASSOCIATES, Washington, D.C., for Amicus The Galen Institute. Mark R. Herring, Attorney General, Cynthia E. Hudson, Chief Deputy Attorney General, Trevor S. Cox, Deputy Solicitor General, OFFICE OF THE ATTORNEY GENERAL OF VIRGINIA, Richmond, Virginia, for Amicus

Commonwealth of Virginia. Joseph Miller, Julie Simon Miller, AMERICA'S HEALTH INSURANCE PLANS, Washington, D.C.; Andrew J. Pincus, Brian D. Netter, MAYER BROWN LLP, Washington, D.C., for Amicus America's Health Insurance Plans. Mary P. Rouvelas, AMERICAN CANCER SOCIETY CANCER ACTION NETWORK, Washington, D.C.; Brian G. Eberle, SHERMAN & HOWARD L.L.C., Denver, Colorado, for Amici American Cancer Society, American Cancer Society Cancer Action Network, American Diabetes Association, and American Heart Association. Clint A. Carpenter, H. Guy Collier, Ankur J. Goel, Cathy Z. Scheineson, Lauren A. D'Agostino, MCDERMOTT WILL & EMERY LLP, Washington, D.C., for Amicus Public Health Deans, Chairs, and Faculty. Elizabeth B. Wydra, Douglas T. Kendall, Simon Lazarus, Brianne J. Gorod, CONSTITUTIONAL ACCOUNTABILITY CENTER, Washington, D.C., for Amicus Members of Congress and State Legislators. Melinda Reid Hatton, Maureen Mudron, AMERICAN HOSPITAL ASSOCIATION, Washington, D.C.; Dominic F. Perella, Sean Marotta, HOGAN LOVELLS US LLP, Washington, D.C., for Amicus American Hospital Association. Matthew S. Hellman, Matthew E. Price, Julie Straus Harris, Previn Warren, JENNER & BLOCK LLP, Washington, D.C., for Amicus Economic Scholars. Robert N. Weiner, Michael Tye, ARNOLD & PORTER LLP, Washington, D.C., for Amicus Families USA. Stuart R. Cohen, Michael Schuster, AARP FOUNDATION LITIGATION, Washington, D.C.; Martha Jane Perkins, NATIONAL HEALTH LAW PROGRAM, Carrboro, North Carolina, for Amici AARP and National Health Law Program.

GREGORY, Circuit Judge:

The plaintiffs-appellants bring this suit challenging the validity of an Internal Revenue Service ("IRS") final rule implementing the premium tax credit provision of the Patient Protection and Affordable Care Act (the "ACA" or "Act"). The final rule interprets the ACA as authorizing the IRS to grant tax credits to individuals who purchase health insurance on both state-run insurance "Exchanges" and federally-facilitated "Exchanges" created and operated by the Department of Health and Human Services ("HHS"). The plaintiffs contend that the IRS's interpretation is contrary to the language of the statute, which, they assert, authorizes tax credits only for individuals who purchase insurance on state-run Exchanges. For reasons explained below, we find that the applicable statutory language is ambiguous and subject to multiple interpretations. Applying deference to the IRS's determination, however, we uphold the rule as a permissible exercise of the agency's discretion. We thus affirm the judgment of the district court.

I.

In March of 2010, Congress passed the ACA to "increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus, v. Sebelius*, 132 S. Ct. 2566, 2580 (2012) (*NFIB*). To increase the availability of affordable insurance plans, the Act provides for the establishment of "Exchanges," through which individuals can purchase competitively-priced health care coverage. *See* ACA §§ 1311, 1321. Critically, the Act provides a federal tax credit to millions of low- and middle-income Americans to offset the cost of

insurance policies purchased on the Exchanges. *See* 26 U.S.C. § 36B. The Exchanges facilitate this process by advancing an individual's eligible tax credit dollars directly to health insurance providers as a means of reducing the up-front cost of plans to consumers.

Section 1311 of the Act provides that "[e]ach State shall, not later than January 1, 2014, establish an American Health Benefit Exchange." ACA § 1311(b)(1). However, § 1321 of the Act clarifies that a state may "elect" to establish an Exchange. Section 1321(c) further provides that if a state does not "elect" to establish an Exchange by January 1, 2014, or fails to meet certain federal requirements for the Exchanges, "the Secretary [of HHS] shall establish and operate such exchange within the State " ACA § 1321(c)(1). Only sixteen states plus the District of Columbia have elected to set up their own Exchanges; the remaining thirty-four states rely on federally-facilitated Exchanges.

Eligibility for the premium tax credits is calculated according to 26 U.S.C. § 36B. This section defines the annual "premium assistance credit amount" as the sum of the monthly premium assistance amounts for "all coverage months of the taxpayer occurring during the taxable year." *Id.* § 36B(b)(1). A "coverage month" is one in which the taxpayer is enrolled in a health plan "through an Exchange established by the State under section 1311." *Id.* § 36B(c)(2)(A)(i); see also id. § 36B(b)(2)(A)-(B) (calculating the premium assistance amount in relation to the price of premiums available and enrolled in "through an Exchange established by the State under [§] 1311").

In addition to the tax credits, the Act requires most Americans to obtain "minimum essential" coverage or pay a tax penalty imposed by the IRS. *Id.* § 5000A; *NFIB*, 132 S. Ct. at 2580. However, the Act includes an unaffordability exemption that excuses low-income individuals for whom the annual cost of health coverage exceeds eight percent of their projected household income. 26 U.S.C. § 5000A(e) (1) (A). The cost of coverage is calculated as the annual premium for the least expensive insurance plan available on an Exchange offered in a consumer's state, minus the tax credit described above. *Id.* § 5000A(e) (1) (B) (ii). The tax credits thereby reduce the number of individuals exempt from the minimum coverage requirement, and in turn increase the number of individuals who must either purchase health insurance coverage, albeit at a discounted rate, or pay a penalty.

The IRS has promulgated regulations making the premium tax credits available to qualifying individuals who purchase health insurance on both state-run and federally-facilitated Exchanges. *See* 26 C.F.R. § 1.36B-l(k); Health Insurance Premium Tax 7 Credit, 77 Fed. Reg. 30,377, 30,378 (May 23, 2012) (collectively the "IRS Rule"). The IRS Rule provides that the credits shall be available to anyone "enrolled in one or more qualified health plans through an Exchange," and then adopts by cross-reference an HHS definition of "Exchange" that includes any Exchange, "regardless of whether the Exchange is established and operated by a State or by HHS." 26 C.F.R. § 1.36B-2; 45 C.F.R. § 155.20. Individuals who purchase insurance through federally-facilitated Exchanges are thus eligible for the premium tax credits under the IRS Rule. In response to commentary that this interpretation might conflict

with the text of the statute, the IRS issued the following explanation:

> The statutory language of section 36B and other provisions of the Affordable Care Act support the interpretation that credits are available to taxpayers who obtain coverage through a State Exchange, regional Exchange, subsidiary Exchange, and the Federally-facilitated Exchange. Moreover, the relevant legislative history does not demonstrate that Congress intended to limit the premium tax credit to State Exchanges. Accordingly, the final regulations maintain the rule in the proposed regulations because it is consistent with the language, purpose, and structure of section 36B and the Affordable Care Act as a whole.

77 Fed. Reg. at 30,378.

The plaintiffs in this case are Virginia residents who do not want to purchase comprehensive health insurance. Virginia has declined to establish a state-run Exchange and is therefore served by the prominent federally-facilitated Exchange known as HealthCare.gov. Without the premium tax credits, the plaintiffs would be exempt from the individual mandate under the unaffordability exemption. With the credits, however, the reduced costs of the policies available to the plaintiffs subject them to the minimum coverage penalty. According to the plaintiffs, then, as a result of the IRS Rule, they will incur some financial cost because they will be forced either to purchase insurance or pay the individual mandate penalty.

The plaintiffs' complaint alleges that the IRS Rule exceeds the agency's statutory authority, is arbitrary and capricious, and is contrary to law in violation of

the Administrative Procedure Act ("APA"), 5 U.S.C. § 706. The plaintiffs contend that the statutory language calculating the amount of premium tax credits according to the cost of the insurance policy that the taxpayer "enrolled in through an *Exchange established by the State under [§ 1311]*" precludes the IRS's interpretation that the credits are also available on national Exchanges. 26 U.S.C. § 36B(b) (2) (A), (c) (2) (A) (i) (emphasis added). The district court disagreed, finding that the statute as a whole clearly evinced Congress's intent to make the tax credits available nationwide. The district court granted the defendants' motion to dismiss, and the plaintiffs timely appealed.

II.

We must first address whether the plaintiffs' claims are justiciable. The defendants make two arguments on this point: (1) that the plaintiffs lack standing; and (2) that the availability of a tax-refund action acts as an independent bar to the plaintiffs' claims under the APA.

A.

We review de novo the legal question of whether plaintiffs have standing to sue. *Wilson v. Dollar General Corp.*, 717 F.3d 337, 342 (4th Cir. 2013). Article III standing requires a litigant to demonstrate "an invasion of a legally protected interest" that is "concrete and particularized" and "'actual or imminent.'" *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992) (quoting *Whitmore v. Arkansas*, 495 U.S. 149, 155 (1990)). The plaintiffs premise their standing on the claim that, if they were not eligible for the premium tax credits, they would qualify for the unaffordability exemption in 26 U.S.C. § 5000A

and would therefore not be subject to the tax penalty for failing to maintain minimum essential coverage. Thus, because of the credits, the plaintiffs argue that they face a direct financial burden because they are forced either to purchase insurance or pay the penalty.

We agree that this represents a concrete economic injury that is directly traceable to the IRS Rule. The IRS Rule forces the plaintiffs to purchase a product they otherwise would not, at an expense to them, or to pay the tax penalty for failing to comply with the individual mandate, also subjecting them to some financial cost. Although it is counterintuitive, the tax credits, working in tandem with the Act's individual mandate, impose a financial burden on the plaintiffs.

The defendants' argument against standing is premised on the claim that the plaintiffs want to purchase "catastrophic" insurance coverage, which in some cases is more expensive than subsidized comprehensive coverage required by the Act. The defendants thus claim that the plaintiffs have acknowledged they would actually expend *more* money on a separate policy even if they were eligible for the credits. Regardless of the viability of this argument, it rests on an incorrect premise. The defendants misread the plaintiffs' complaint, which, while mentioning the possibility that several of the plaintiffs wish to purchase catastrophic coverage, also clearly alleges that each plaintiff does not want to buy comprehensive, ACA-compliant coverage and is harmed by having to do so or pay a penalty. The harm in this case is having to choose between ACA-compliant coverage and the penalty, both of which represent a financial cost to the plaintiffs. That harm

is actual or imminent, and is directly traceable to the IRS Rule. The plaintiffs thus have standing to present their claims.

B.

The defendants also argue that the availability of a tax-refund action bars the plaintiffs' claims under the APA. The defendants assert that the proper course of action for the plaintiffs is to pay the tax penalty and then present their legal arguments against the IRS Rule as part of a tax-refund action brought under either 26 U.S.C. § 7422(a) ("No suit or proceeding shall be maintained in any court for the recovery of any internal revenue tax alleged to have been erroneously or illegally assessed or collected, until a claim for refund or credit has been duly filed. "), or the Little Tucker Act, 28 U.S.C. § 1346 (granting district courts jurisdiction to hear "[a]ny civil action against the United States for the recovery of any internal-revenue tax alleged to have been erroneously or illegally assessed or collected, or any penalty claimed to have been collected without authority or any sum alleged to have been excessive or in any manner wrongfully collected under the internal-revenue laws").[1] The defendants do not, nor could they, assert this as a jurisdictional bar, but instead point to "general equitable principles disfavoring the issuance of federal injunctions against taxes, absent clear proof that available remedies at law [are] inadequate." *Bob Jones Univ. v. Simon*, 416 U.S. 725, 742 n.16 (1974). The defendants argue that a tax

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[1] Although 26 U.S.C. § 7422(a) does not appear to specifically authorize suits, § 6532 speaks of refund suits filed "under § 7422(a)." *See also Cohen v. United States*, 650 F.3d 717, 731, n.11 (D.C. Cir. 2011) (en banc).

refund action presents an "adequate remedy" that the plaintiffs must first pursue before challenging the IRS Rule directly under the APA. *See* 5 U.S.C. § 704 ("Agency action made reviewable by statute and final agency action for which there is no other adequate remedy in a court are subject to judicial review.").

The defendants' arguments are not persuasive. First, they fail to point to a single case in which a court has refused to entertain a similar suit on the grounds that the parties were required to first pursue a tax-refund action under 26 U.S.C. § 7422(a) or 28 U.S.C. § 1346. Moreover, the plaintiffs are not seeking a tax refund; they ask for no monetary relief, alleging instead claims for declaratory and injunctive relief in an attempt to forestall the lose-lose choice (in their minds) of purchasing a product they do not want or paying the penalty. Section 7422 (a) does not allow for prospective relief. Instead, it bars suit "for the *recovery* of any internal revenue tax alleged to have been erroneously or illegally assessed or collected." 26 U.S.C. 7422(a) (emphasis added); *see also Cohen*, 650 F.3d at 732 ("[Section 7422(a)] does not, at least explicitly, allow for prospective relief."). Similarly, "[t]he Little Tucker Act does not authorize claims that seek primarily equitable relief." *Berman v. United States*, 264 F.3d 16, 21 (1st Cir. 2001) (citing *Richardson v. Morris*, 409 U.S. 464, 465 (1973); *Bobula v. United States Dep't of Justice*, 970 F.2d 854, 858-59 (Fed. Cir. 1992)).

It is clear, then, that the alternative forms of relief suggested by the defendants would not afford the plaintiffs the complete relief they seek. This is simply not a typical tax refund action in which an individual taxpayer complains of the manner in which a tax was

assessed or collected and seeks reimbursement for wrongly paid sums. The plaintiffs here challenge the legality of a final agency action, which is consistent with the APA's underlying purpose of "remov[ing] obstacles to judicial review of agency action." *Bowen v. Massachusetts*, 487 U.S. 879, 904 (1988). Requiring the plaintiffs to choose between purchasing insurance and thereby waiving their claims or paying the tax and challenging the IRS Rule after the fact creates just such an obstacle. We therefore find that the plaintiffs' suit is not barred under the APA.

III.

Turning to the merits, "we review questions of statutory construction de novo." *Orquera v. Ashcroft*, 357 F.3d 413, 418 (4th Cir. 2003). Because this case concerns a challenge to an agency's construction of a statute, we apply the familiar two-step analytic framework set forth in *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984). At *Chevron's* first step, a court looks to the "plain meaning" of the statute to determine if the regulation responds to it. *Chevron*, 467 U.S. at 842-43. If it does, that is the end of the inquiry and the regulation stands. *Id.* However, if the statute is susceptible to multiple interpretations, the court then moves to *Chevron's* second step and defers to the agency's interpretation so long as it is based on a permissible construction of the statute. *Id.* at 843.

A.

At step one, "[i]f the statute is clear and unambiguous 'that is the end of the matter, for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.'" *Bd. of Governors of the Fed. Reserve Sys. v. Dimension Fin.*

Corp., 474 U.S. 361, 368 (1986) (quoting *Chevron*, 467 U.S. at 842-43). A statute is ambiguous only if the disputed language is "reasonably susceptible of different interpretations." *Nat'l R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 473 n.27 (1985). "The objective of *Chevron* step one is not to interpret and apply the statute to resolve a claim, but to determine whether Congress's intent in enacting it was so clear as to foreclose any other interpretation." *Grapevine Imports, Ltd. v. United States*, 636 F.3d 1367, 1377 (Fed. Cir. 2011). Courts should employ all the traditional tools of statutory construction in determining whether Congress has clearly expressed its intent regarding the issue in question. *Chevron*, 467 U.S. at 843 n.9; *Nat'l Elec. Mfrs. Ass'n v. U.S. Dep't of Energy*, 654 F.3d 496, 504 (4th Cir. 2011).

1.

In construing a statute's meaning, the court "begin [s], as always, with the language of the statute." *Duncan v. Walker*, 533 U.S. 167, 172 (2001). As described above, 26 U.S.C. § 36B provides that the premium assistance amount is the sum of the monthly premium assistance amounts for all "coverage months" for which the taxpayer is covered during a year. A "coverage month" is one in which "the taxpayer is covered by a qualified health plan . enrolled in through an Exchange established by the State under [§] 1311 of the [Act]." 26 U.S.C. § 36B(b)(2)(A). Similarly, the statute calculates an individual's tax credit by totaling the "premium assistance amounts" for all "coverage months" in a given year. Id. § 36B(b) (1). The "premium assistance amount" is based in part on the cost of the monthly

premium for the health plan that the taxpayer purchased "through an Exchange established by the State under [§] 1311." Id. § 36B(b)(2).

The plaintiffs assert that the plain language of both relevant subsections in § 36B is determinative. They contend that in defining the terms "coverage months" and "premium assistance amount" by reference to Exchanges that are "established by the State under [§] 1311," Congress limited the availability of tax credits to individuals purchasing insurance on state Exchanges. Under the plaintiffs' construction, the premium credit amount for individuals purchasing insurance through a federal Exchange would always be zero.

The plaintiffs' primary rationale for their interpretation is that the language says what it says, and that it clearly mentions state-run Exchanges under § 1311. If Congress meant to include federally-run Exchanges, it would not have specifically chosen the word "state" or referenced § 1311. The federal government is not a "State," and so the phrase "Exchange established by the State under [§] 1311," standing alone, supports the notion that credits are unavailable to consumers on federal Exchanges. Further, the plaintiffs assert that because state and federal Exchanges are referred to separately in § 1311 and § 1321, the omission in 26 U.S.C. § 36B of any reference to federal Exchanges established under § 1321 represents an intentional choice on behalf of Congress to exclude federal Exchanges and include only state Exchanges established under § 1311.

There can be no question that there is a certain sense to the plaintiffs' position. If Congress did in fact intend to make the tax credits available to

consumers on both state and federal Exchanges, it would have been easy to write in broader language, as it did in other places in the statute. *See* 42 U.S.C. § 18032(d)(3)(D)(i)(II) (referencing Exchanges "established under this Act").

However, when conducting statutory analysis, "a reviewing court should not confine itself to examining a particular statutory provision in isolation. Rather, [t]he meaning – or ambiguity – of certain words or phrases may only become evident when placed in context." *Nat'l Ass'n of Home Builders v. Defenders of Wildlife*, 551 U.S. 644, 666 (2007) (internal citation and quotation marks omitted). With this in mind, the defendants' primary counterargument points to ACA §§ 1311 and 1321, which, when read in tandem with 26 U.S.C. § 36B, provide an equally plausible understanding of the statute, and one that comports with the IRS's interpretation that credits are available nationwide.

As noted, § 1311 provides that "[e]ach State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an "Exchange") [.]" It goes on to say that "[a]n Exchange shall be a governmental agency or nonprofit entity that is established by a State," apparently narrowing the definition of "Exchange" to encompass only state-created Exchanges. ACA § 1311(d)(1). Similarly, the definitions section of the Act, § 1563(b), provides that "[t]he term 'Exchange' means an American Health Benefit Exchange established under [§] 1311," further supporting the notion that all Exchanges should be considered as if they were established by a State.

Of course, § 1311's directive that each State establish an Exchange cannot be understood literally in light of § 1321, which provides that a state may "elect" to do so. Section 1321(c) provides that if a state fails to establish an Exchange by January 1, 2014, the Secretary "shall establish and operate *such Exchange* within the State and the Secretary shall take such actions as are necessary to implement such other requirements." (emphasis added). The defendants' position is that the term "such Exchange" refers to a state Exchange that is set up and operated by HHS. In other words, the statute mandates the existence of state Exchanges, but directs HHS to establish such Exchanges when the states fail to do so themselves. In the absence of state action, the federal government is required to step in and create, by definition, "an American Health Benefit Exchange established under [§] 1311" on behalf of the state.

Having thus explained the parties' competing primary arguments, the court is of the opinion that the defendants have the stronger position, although only slightly. Given that Congress defined "Exchange" as an Exchange established by the state, it makes sense to read § 1321(c)'s directive that HHS establish "such Exchange" to mean that the federal government acts on behalf of the state when it establishes its own Exchange. However, the court cannot ignore the common-sense appeal of the plaintiffs' argument; a literal reading of the statute undoubtedly accords more closely with their position. As such, based solely on the language and context of the most relevant statutory provisions, the court cannot say that Congress's intent is so clear and unambiguous that it "foreclose[s] any other interpretation." *Grapevine Imports*, 636 F.3d at 1377.

2.

We next examine two other, less directly relevant provisions of the Act to see if they shed any more light on Congress's intent. *Food and Drug Admin, v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 132-33 (2000) ("A court must . interpret the statute as a symmetrical and coherent regulatory scheme, and fit, if possible, all parts into a harmonious whole.") (citation and internal quotation marks omitted). First, the defendants argue that reporting provisions in § 36B(f) conflict with the plaintiffs' interpretation and confirm that the premium tax credits must be available on federally-run Exchanges. Section 36B(f) – titled "Reconciliation of credit and advance credit" – requires the IRS to reduce the amount of a taxpayer's end-of-year premium tax credit by the amount of any advance payment of such credit. *See* 26 U.S.C. § 36B(f)(l) ("The amount of the credit allowed under this section for any taxable year shall be reduced (but not below zero) by the amount of any advance payment of such credit[.]"). To enable the IRS to track these advance payments, the statute requires "*[e]ach* Exchange (or any person carrying out 1 or more responsibilities of an Exchange under section 1311(f) (3) *or 1321(c)* of the [Act])" to provide certain information to the Department of the Treasury. *Id.* § 36B(f)(3) (emphasis added). There is no dispute that the reporting requirements apply regardless of whether an Exchange was established by a state or HHS. The Exchanges are required to report the following information:

(A) The level of coverage described in section 1302(d) of the Patient Protection and

Affordable Care Act and the period such coverage was in effect.

(B) The total premium for the coverage without regard to the credit under this section or cost-sharing reductions under section 1402 of such Act.

(C) The aggregate amount of any advance payment of such credit or reductions under section 1412 of such Act.

(D) The name, address, and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy.

(E) Any information provided to the Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of, such credit.

(F) Information necessary to determine whether a taxpayer has received excess advance payments.

Id.

The defendants argue, sensibly, that if premium tax credits were not available on federally-run Exchanges, there would be no reason to require such Exchanges to report the information found in subsections (C), (E), and (F). It is therefore possible to infer from the reporting requirements that Congress intended the tax credits to be available on both state- and federally-facilitated Exchanges. The plaintiffs acknowledge that some of the reporting requirements are extraneous for federally-run Exchanges, but note that the other categories of reportable information, i.e., subsections (A), (B), and (D), remain relevant even in the absence of credits.

The plaintiffs suggest that Congress was simply saving itself the trouble of writing two separate subsections, one for each type of Exchange, by including a single comprehensive list.

The second source of potentially irreconcilable language offered by the defendants concerns the "qualified individuals" provision under ACA § 1312. That section sets forth provisions regarding which individuals may purchase insurance from the Exchanges. It provides that only "qualified individuals" may purchase health plans in the individual markets offered through the Exchanges, and explains that a "qualified individual" is a person who "resides in the State that established the Exchange." ACA § 1312. The defendants argue that unless their reading of § 1321 is adopted and understood to mean that the federal government stands in the shoes of the state for purposes of establishing an Exchange, there would be no "qualified individuals" existing in the thirty-four states with federally-facilitated Exchanges because none of those states is a "State that established the Exchange." This would leave the federal Exchanges with no eligible customers, a result Congress could not possibly have intended.

The plaintiffs acknowledge that this would be untenable, and suggest that the residency requirement is only applicable to state-created Exchanges. They note that § 1312 states that a "qualified individual" – "*with respect to an Exchange*" – is one who "resides in the State that established the Exchange." ACA § 1312(f)(1)(A) (emphasis added). Accordingly, because "Exchange" is defined as an Exchange established under § 1311, i.e., the provision

directing *states* to establish Exchanges, the residency requirement only limits enrollment on state Exchanges.

Having considered the parties' competing arguments on both of the above-referenced sections, we remain unpersuaded by either side. Again, while we think the defendants make the better of the two cases, we are not convinced that either of the purported statutory conflicts render Congress's intent clear. Both parties offer reasonable arguments and counterarguments that make discerning Congress's intent difficult. Additionally, we note that the Supreme Court has recently reiterated the admonition that courts avoid revising ambiguously drafted legislation out of an effort to avoid "apparent anomal[ies]" within a statute. *Michigan v. Bay Mills Indian Cmty.*, No. 12-515, 572 U.S. _, ___, slip op. at 10 (May 27, 2014). It is not especially surprising that in a bill of this size – "10 titles stretch[ing] over 900 pages and contain[ing] hundreds of provisions," *NFIB*, 132 S. Ct. at 2580, – there would be one or more conflicting provisions. *See Bay Mills*, at 10-11 ("Truth be told, such anomalies often arise from statutes, if for no other reason than that Congress typically legislates by parts "). Wary of granting excessive analytical weight to relatively minor conflicts within a statute of this size, we decline to accept the defendants' arguments as dispositive of Congress's intent.

3.

The Act's legislative history is also not particularly illuminating on the issue of tax credits. *See Philip Morris USA, Inc. v. Vilsack*, 736 F.3d 284, 289 (4th Cir. 2013) (considering legislative history at *Chevron*

step one). *But see Nat'l Elec. Mfrs. Ass'n*, 654 F.3d at 505 (noting that, "in consulting legislative history at step one of *Chevron*, we have utilized such history only for limited purposes, and only after exhausting more reliable tools of construction"). As both parties concede, the legislative history of the Act is somewhat lacking, particularly for a bill of this size.[2] Several floor statements from Senators support the notion that it was well understood that tax credits would be available for low- and middle-income Americans nationwide. For example, Senator Baucus stated that the "tax credits will help to ensure all Americans can afford quality health insurance." 155 Cong. Rec. S11,964 (Nov. 21, 2009). He later estimated that "60 percent of those who are getting insurance in the individual market on the exchange will get tax credits " 155 Cong. Rec. S12,764 (Dec. 9, 2009). Similarly, Senator Durbin stated that half of the "30 million Americans today who have no health insurance will qualify for tax credits to help them pay their premiums so they can have and afford health insurance." 155 Cong. Rec. S13,559 (Dec. 20, 2009). These figures only make sense if all financially eligible Americans are understood to have access to the credits.

However, it is possible that such statements were made under the assumption that every state would in

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[2] As another court considering a similar challenge to the IRS Rule recently noted, "[b]ecause the House and Senate versions of the Act were synthesized through a reconciliation process, rather than the standard conference committee process, no conference report was issued for the Act, and there is a limited legislative record relating to the final version of the bill." *Halbig v. Sebelius*, No. 13-623, 2014 WL 129023, at *17 n.13 (D.D.C. Jan. 15, 2014).

fact establish its own Exchange. As the district court stated, "Congress did not expect the states to turn down federal funds and fail to create and run their own Exchanges." *King v. Sebelius*, No. 3:13-cv-630, 2014 WL 637365, at *14 (E.D. Va. Feb. 18, 2014). The Senators' statements therefore do not necessarily address the question of whether the credits would remain available in the absence of state-created Exchanges. The plaintiffs argue extensively that Congress could not have anticipated that so few states would establish their own Exchanges. Indeed, they argue that Congress attempted to "coerce" the states into establishing Exchanges by conditioning the availability of the credits on the presence of state Exchanges. The plaintiffs contend that Congress struck an internal bargain in which it decided to favor state-run Exchanges by incentivizing their creation with billions of dollars of tax credits. According to the plaintiffs, however, Congress's plan backfired when a majority of states refused to establish their own Exchanges, in spite of the incentives. The plaintiffs thus acknowledge that the lack of widely available tax credits is counter to Congress's original intentions, but consider this the product of a Congressional miscalculation that the courts have no business correcting.

Although the plaintiffs offer no compelling support in the legislative record for their argument,[3] it is at

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[3] The plaintiffs take an isolated, stray comment from Senator Baucus during a Senate Finance Committee hearing well out of context, see J.A. 285-87, and similarly place too much emphasis on a draft bill from the Senate Health, Education, Labor, and Pensions Committee that would have conditioned subsidies for a state's residents on the state's adoption of certain "insurance

least plausible that Congress would have wanted to ensure state involvement in the creation and operation of the Exchanges. Such an approach would certainly comport with a literal reading of 26 U.S.C. § 36B's text. In any event, it is certainly possible that the Senators quoted above were speaking under the assumption that each state would establish its own Exchange, and that they could not have envisioned the issue currently being litigated. Although Congress included a fallback provision in the event the states failed to act, it is not clear from the legislative record how large a role Congress expected the federal Exchanges to play in administering the Act. We are thus of the opinion that nothing in the legislative history of the Act provides compelling support for either side's position.

Having examined the plain language and context of the most relevant statutory sections, the context and structure of related provisions, and the legislative history of the Act, we are unable to say definitively that Congress limited the premium tax credits to individuals living in states with state-run Exchanges. We note again that, on the whole, the defendants have the better of the statutory construction arguments, but that they fail to carry the day. Simply put, the statute is ambiguous and subject to at least two different interpretations. As a result, we are unable to resolve the case in either party's favor at the first step of the *Chevron* analysis.

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reform provisions," *see* S. 1679, § 3104(a), (d)(2), 111th Cong. (2009).

B.

Finding that Congress has not "directly spoken to the precise question at issue," we move to *Chevron's* second step. 467 U.S. at 842. At step two, we ask whether the "agency's [action] is based on a permissible construction of the statute." *Id.* at 843. We "will not usurp an agency's interpretive authority by supplanting its construction with our own, so long as the interpretation is not 'arbitrary, capricious, or manifestly contrary to the statute.' A construction meets this standard if it 'represents a reasonable accommodation of conflicting policies that were committed to the agency's care by the statute.'" *Philip Morris*, 736 F.3d at 290 (quoting *Chevron*, 467 U.S. at 844, 845). We have been clear that "[r]eview under this standard is highly deferential, with a presumption in favor of finding the agency action valid." *Ohio Vall. Envt'l Coalition v. Aracoma Coal Co.*, 556 F.3d 177, 192 (4th Cir. 2009).

As explained, we cannot discern whether Congress intended one way or another to make the tax credits available on HHS-facilitated Exchanges. The relevant statutory sections appear to conflict with one another, yielding different possible interpretations. In light of this uncertainty, this is a suitable case in which to apply the principles of deference called for by *Chevron*. *See Scialabba v. Cuellar de Osorio*, No. 12-930, 573 U.S. ___, ___, slip op. at 14 (June 9, 2014) ("[I]nternal tension [in a statute] makes possible alternative reasonable constructions, bringing into correspondence in one way or another the section's different parts. And when that is so, *Chevron* dictates that a court defer to the agency's choice ") (plurality opinion); *Nat'l Elec. Mfrs. Ass'n*, 654 F.3d at

505 ("[W]e have reached *Chevron's* second step after describing statutory language as 'susceptible to more precise definition and open to varying constructions.'") (quoting *Md. Dep't of Health and Mental Hygiene v. Centers for Medicare and Medicaid Servs.*, 542 F.3d 424, 434 (4th Cir. 2008)).[4]

What we must decide is whether the statute permits the IRS to decide whether the tax credits would be available on federal Exchanges. In answering this question in the affirmative we are primarily persuaded by the IRS Rule's advancement of the broad policy goals of the Act. *See Vill. of*

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[4] We recognize that not every ambiguity in a statute gives rise to *Chevron* deference. Often, but not always, courts will yield to an agency's interpretation only when the ambiguity creates some discretionary authority for the agency to fulfill. *See Chamber of Commerce of U.S. v. N.L.R.B.*, 721 F.3d 152, 161 (4th Cir. 2013) ("'Mere ambiguity in a statute is not evidence of congressional delegation of authority.' Rather, '[t]he ambiguity must be such as to make it appear that Congress either explicitly or implicitly delegated authority to cure that ambiguity.'") (quoting *Am. Bar Ass'n v. F.T.C.*, 430 F.3d 457, 469 (D.C. Cir. 2005)) (alteration in original). However, given the importance of the tax credits to the overall statutory scheme, it is reasonable to assume that Congress created the ambiguity in this case with at least some degree of intentionality. *See City of Arlington v. F.C.C.*, 133 S. Ct. 1863, 1868 (2013) ("Congress knows to speak in plain terms when it wishes to circumscribe, and in capacious terms when it wishes to enlarge, agency discretion."). There are several possible reasons for leaving an ambiguity of this sort: Congress perhaps might not have wanted to resolve a politically sensitive issue; additionally, it might have intended to see how large a role the states were willing to adopt on their own before having the agency respond with rules that could best effectuate the purpose of the Act in light of the actual circumstances present several years after the bill's passage.

Barrington v. Surface Transp. Bd., 636 F.3d 650, 666 (D.C. Cir. 2011) ("[W]hen an agency interprets ambiguities in its organic statute, it is entirely appropriate for that agency to consider policy arguments that are rationally related to the [statute's] goals." (internal quotation marks and citation omitted)); *Ariz. Pub. Serv. Co. v. EPA*, 211 F.3d 1280, 1287 (D.C. Cir. 2000) ("[A]s long as the agency stays within [Congress's] delegation, it is free to make policy choices in interpreting the statute, and such interpretations are entitled to deference.") (quotation marks omitted). There is no question that the Act was intended as a major overhaul of the nation's entire health insurance market. The Supreme Court has recognized the broad policy goals of the Act: "to increase the number of Americans covered by health insurance and decrease the cost of health care." *NFIB*, 132 S. Ct. at 2580. Similarly, Title I of the ACA is titled "Quality, Affordable Health Care for *All* Americans" (emphasis added).

Several provisions of the Act are necessary to achieving these goals. To begin with, the individual mandate requires nearly all Americans to have health insurance or pay a fine. Increasing the pool of insured individuals has the intended side-effect of increasing revenue for insurance providers. The increased revenue, in turn, supports several more specific policy goals contained in the Act. The most prominent of these are the guaranteed-issue and community-rating provisions. In short, these provisions bar insurers from denying coverage or charging higher premiums because of an individual's health status. *See* ACA § 1201. However, these requirements, standing alone, would result in an "adverse selection" scenario whereby individuals

disproportionately likely to utilize health care would drive up the costs of policies available on the Exchanges.

Congress understood that one way to avoid such price increases was to require near-universal participation in the insurance marketplace via the individual mandate. In combination with the individual mandate, Congress authorized broad incentives – totaling hundreds of billions of dollars – to further increase market participation among low- and middle-income individuals. A Congressional Budget Office report issued while the Act was under consideration informed Congress that there would be an "an influx of enrollees with below-average spending for health care, who would purchase coverage because of the new subsidies to be provided and the individual mandate to be imposed." J.A. 95. The report further advised Congress that "[t]he substantial premium subsidies available in the exchanges would encourage the enrollment of a broad range of people"; and that the structure of the premium tax credits, under which federal subsidies increase if premiums rise, "would dampen the chances that a cycle of rising premiums and declining enrollment would ensue." J.A. 108-109. As the defendants further explain, denying tax credits to individuals shopping on federal Exchanges would throw a debilitating wrench into the Act's internal economic machinery:

> Insurers in States with federally-run Exchanges would still be required to comply with guaranteed-issue and community-rating rules, but, without premium tax subsidies to encourage broad participation, insurers would be deprived of the

> broad policy-holder base required to make those reforms viable. Adverse selection would cause premiums to rise, further discouraging market participation, and the ultimate result would be an adverse-selection "death spiral" in the individual insurance markets in States with federally-run Exchanges.

Br. of Appellees, at 35; *see also* Amicus Br. of America's Health Insurance Plans, at 3-6; Amicus Br. for Economic Scholars, at 3-6.[5]

It is therefore clear that widely available tax credits are essential to fulfilling the Act's primary goals and that Congress was aware of their importance when drafting the bill. The IRS Rule advances this understanding by ensuring that this essential component exists on a sufficiently large scale. The IRS Rule became all the more important once a significant number of states indicated their intent to forgo establishing Exchanges. With only sixteen state-run Exchanges currently in place, the economic framework supporting the Act would crumble if the credits were unavailable on federal Exchanges. Furthermore, without an exception to the individual mandate, millions more Americans unable to purchase insurance without the credits would be

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[5] Likewise, four Supreme Court Justices have remarked on the importance of the tax credit system: "Without the federal subsidies, individuals would lose the main incentive to purchase insurance inside the exchanges, and some insurers may be unwilling to offer insurance inside of exchanges. With fewer buyers and even fewer sellers, the exchanges would not operate as Congress intended and may not operate at all." *NFIB*, 132 S. Ct. at 2674 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting).

forced to pay a penalty that Congress never envisioned imposing on them. The IRS Rule avoids both these unforeseen and undesirable consequences and thereby advances the true purpose and means of the Act.

It is thus entirely sensible that the IRS would enact the regulations it did, making *Chevron* deference appropriate. Confronted with the Act's ambiguity, the IRS crafted a rule ensuring the credits' broad availability and furthering the goals of the law. In the face of this permissible construction, we must defer to the IRS Rule. *See Scialabba*, at 33 ("Whatever Congress might have meant in enacting [the statute], it failed to speak clearly. Confronted with a self-contradictory, ambiguous provision in a complex statutory scheme, the Board chose a textually reasonable construction consonant with its view of the purposes and policies underlying immigration law. Were we to overturn the Board in that circumstance, we would assume as our own the responsible and expert agency's role."); *Nat'l Elec. Mfrs. Ass'n*, 654 F.3d at 505 ("[W]e defer at [Chevron's] step two to the agency's interpretation so long as the construction is a reasonable policy choice for the agency to make.") (second alteration in original).

Tellingly, the plaintiffs do not dispute that the premium tax credits are an essential component of the Act's viability. Instead, as explained above, they concede that Congress probably wanted to make subsidies available throughout the country, but argue that Congress was equally concerned with ensuring that the states play a leading role in administering the Act, and thus conditioned the availability of the

credits on the creation of state Exchanges. The plaintiffs argue that the IRS Rule exceeds the agency's authority because it irreconcilably conflicts with Congress's goal of ensuring state leadership. For the reasons explained above, however, we are not persuaded by the plaintiffs' "coercion" argument and do not consider it a valid basis for circumscribing the agency's authority to implement the Act in an efficacious manner.

The plaintiffs also attempt to avert *Chevron* deference by arguing that ACA §§ 1311 and 1321 are administered by HHS and not the IRS, and that as a result the IRS had no authority to enact its final rule. However, the relevant statutory language is found in 26 U.S.C. § 36B, which is part of the Internal Revenue Code and subject to interpretation by the IRS. *See* 77 Fed. Reg. at 30,378 (describing the IRS Rule as a valid interpretation of 26 U.S.C. § 36B). Although the IRS Rule adopts by cross-reference an HHS definition of "Exchange," 26 C.F.R. § 1.36B-1(k), the Act clearly gives to the IRS authority to resolve ambiguities in 26 U.S.C. § 38B ("The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section"). This clear delegation of authority to the IRS relieves us of any possible doubt regarding the propriety of relying on one agency's interpretation of a single piece of a jointly-administered statute.

Finally, the plaintiffs contend that a rule of statutory construction that requires tax exemptions and credits to be construed narrowly displaces *Chevron* deference in this case. However, while the Supreme Court has stated that tax credits "must be expressed in clear and unambiguous terms," *Yazoo &*

Miss. Valley R.R. Co. v. Thomas, 132 U.S. 174, 183 (1889), the Supreme Court has never suggested that this principle displaces *Chevron* deference, and in fact has made it quite clear that it does not. *See Mayo Found. for Medical Educ. and Research v. United States*, 131 S. Ct. 704, 713 (2011) ("[T]he principles underlying our decision in *Chevron* apply with full force in the tax context."); *see also id.* at 712 (collecting cases in which the Supreme Court has applied *Chevron* deference interpreting IRS regulations).

Rejecting all of the plaintiffs' arguments as to why *Chevron* deference is inappropriate in this case, for the reasons explained above we are satisfied that the IRS Rule is a permissible construction of the statutory language. We must therefore apply *Chevron* deference and uphold the IRS Rule.[6]

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[6] The Commonwealth of Virginia, acting as amicus on behalf of the defendants, argues that the plaintiffs' construction of the statute violates the Constitution's Spending Clause by failing to provide Virginia with "clear notice" that receipt of billions of dollars in tax credits for its low- and middle-income citizens was contingent on establishing an Exchange. The Commonwealth's argument derives from *Pennhurst State School & Hospital v. Halderman*, in which the Supreme Court stated that "if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously. By insisting that Congress speak with a clear voice, we enable the States to exercise their choice knowingly, cognizant of the consequences of their participation." 451 U.S. 1, 17 (1981) (internal citations omitted). Although ably advanced, we have no reason to reach the Commonwealth's constitutional argument because we find the IRS Rule to be an appropriate exercise of the agency's authority under Chevron. *See Norfolk S. Ry. Co. v. City of Alexandria*, 608 F.3d 150, 157 (4th Cir. 2010) ("The principle of constitutional avoidance . . requires the federal courts to avoid rendering constitutional rulings unless absolutely necessary.")

Accordingly, the judgment of the district court is affirmed.

AFFIRMED

DAVIS, Senior Circuit Judge, concurring:

I am pleased to join in full the majority's holding that the Patient Protection and Affordable Care Act (the Act) "permits" the Internal Revenue Service to decide whether premium tax credits should be available to consumers who purchase health insurance coverage on federally-run Exchanges. Maj. Op. at 30. But I am also persuaded that, even if one takes the view that the Act is not ambiguous in the manner and for the reasons described, the necessary outcome of this case is precisely the same. That is, I would hold that Congress has mandated in the Act that the IRS provide tax credits to all consumers regardless of whether the Exchange on which they purchased their health insurance coverage is a creature of the state or the federal bureaucracy. Accordingly, at *Chevron* Step One, the IRS Rule making the tax credits available to all consumers of Exchange-purchased health insurance coverage, 26 C.F.R. § 1.36B-1(k), 77 Fed. Reg. 30,377, 30,378 (May 23, 2012), is the correct interpretation of the Act and is required as a matter of law. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984).

Although the Act expressly contemplates state-run Exchanges, ACA § 1311(b)(1), Congress created a contingency provision that permits the federal government, via the Secretary of Health and Human

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(citing *Ashwander v. Tenn. Valley Auth.*, 297 U.S. 288, 347 (1936) (Brandeis, J., concurring)).

Services, to "establish and operate such Exchange within the State and take such actions as are necessary to implement such other requirements." *Id.* § 1321 (c) (1). This contingency provision is triggered when a state elects not to set up an Exchange, when a state is delayed in setting up an Exchange, or when a state Exchange fails to meet certain statutory and regulatory requirements. *Id.* § 1321(c) (1).

Enter the premium tax credits, essentially a tax subsidy for the purchase of health insurance. The amended tax code, 26 U.S.C. § 36B(b), sets forth the formula for calculating the amount of a consumer's premium tax credit. In general, the credit is equal to the lesser of two amounts: the monthly premium for a qualified health plan "enrolled in through an Exchange established by the State," or the excess of the adjusted monthly premium for a certain type of health plan over a percentage of the taxpayer's household income. *Id.* § 36B(b) (2).

Appellants contend that the language "enrolled in through an Exchange *established by the State*" precludes the IRS from providing premium tax credits to consumers who purchase health insurance coverage on federal Exchanges. To them, "established by the State" in the premium tax credits calculation subprovision is the *sine qua non* of this case. An Exchange established by the State is not an Exchange established by the federal government, they argue; thus, the equation for calculating the amount of the premium tax credit is wholly inapplicable to all consumers who purchase health insurance coverage on federally-run Exchanges (the amount would be zero, according to Appellants).

I am not persuaded and for a simple reason: "[E]stablished by the State" indeed means established by the state – except when it does not, i.e., except when a state has failed to establish an Exchange and when the Secretary, charged with acting pursuant to a contingency for which Congress planned, id. § 1321(c), establishes and operates the Exchange in place of the state. When a state elects not to establish an Exchange, the contingency provision authorizes federal officials to establish and operate "such Exchange" and to take any action adjunct to doing so.

That disposes of the Appellants' contention. This is not a case that calls up the decades-long clashes between textualists, purposivists, and other schools of statutory interpretation. *See* Abbe Gluck, The States As Laboratories of Statutory Interpretation: Methodological Consensus and the New Modified Textualism, 119 Yale L.J. 1750, 1762-63 (2010). The case can be resolved through a contextual reading of a few different subsections of the statute. If there were any remaining doubt over this construction, the bill's structure dispels it: The contingency provision at § 1321 (c) (1) is set forth in "Part III" of the bill, titled "State Flexibility Relating to Exchanges," a section that appears *after* the section that creates the Exchanges and mandates that they be operated by state governments, ACA § 1311(b). What's more, the contingency provision does not create two-tiers of Exchanges; there is no indication that Congress intended the federally-operated Exchanges to be lesser Exchanges and for consumers who utilize them to be less entitled to important benefits. Thus, I conclude that a holistic reading of the Act's text and proper attention to its structure lead to only one sensible conclusion: The premium tax credits must be

available to consumers who purchase health insurance coverage through their designated Exchange regardless of whether the Exchange is state- or federally-operated.

The majority opinion understandably engages with the Appellants and respectfully posits they could be perceived to advance a plausible construction of the Act, i.e., that Congress may have sought to restrict the scope of the contingency provision when it used the phrase "established by the State" in the premium tax credits calculation subprovision. But as the majority opinion deftly illustrates, a straightforward reading of the Act strips away any and all possible explanations for why Congress would have intended to exclude consumers who purchase health insurance coverage on federally-run Exchanges from qualifying for premium tax credits. (The best Appellants can come up with seems to be some non-existent Congressional desire for "state leadership" (whatever that means) in effecting a comprehensive overhaul of the nation's health insurance marketplaces and related health care markets.) Such a reading, the majority opinion persuasively explains, is not supported by the legislative history or by the overall structure of the Act. Maj. Op. at 27, 24. Moreover, the majority carefully and cogently explains how "widely available tax credits are essential to fulfilling the Act's primary goals and [how] Congress was aware of their importance when drafting the bill." Maj. Op. at 33. Thus, the majority correctly holds that Congress did not intend a reading that has no legislative history to support it and runs contrary to the Act's text, structure, and goals. Appellants' "literal reading" of the premium tax credits calculation subprovision renders the entire

Congressional scheme nonsensical. *Cf.* Maj. Op. at 27.

In fact, Appellants' reading is not literal; it's cramped. No case stands for the proposition that literal readings should take place in a vacuum, acontextually, and untethered from other parts of the operative text; indeed, the case law indicates the opposite. *National Association of Home Builders v. Defenders of Wildlife*, 551 U.S. 644, 666 (2007). So does common sense: If I ask for pizza from Pizza Hut for lunch but clarify that I would be fine with a pizza from Domino's, and I then specify that I want ham and pepperoni on my pizza from Pizza Hut, my friend who returns from Domino's with a ham and pepperoni pizza has still complied with a literal construction of my lunch order. That is this case: Congress specified that Exchanges should be established and run by the states, but the contingency provision permits federal officials to act in place of the state when it fails to establish an Exchange. The premium tax credit calculation subprovision later specifies certain conditions regarding state-run Exchanges, but that does not mean that a literal reading of that provision somehow precludes its applicability to substitute federally-run Exchanges or erases the contingency provision out of the statute.

That Congress sometimes specified state *and* federal Exchanges in the bill is as unremarkable as it is unrevealing. This was, after all, a 900-page bill that purported to restructure the means of providing health care in this country. Neither the canons of construction nor any empirical analysis suggests that congressional drafting is a perfectly harmonious, symmetrical, and elegant endeavor. *See generally*

Abbe Gluck & Lisa Schultz Bressman, Statutory Interpretation from the Inside: An Empirical Study of Congressional Drafting, Delegation, and the Canons: Part I, 65 Stan. L. Rev. 901 (2013). Sausage-makers are indeed offended when their craft is linked to legislating. Robert Pear, If Only Laws Were Like Sausages, N.Y. Times, Dec. 5, 2010, at WK3. At worst, the drafters' perceived inconsistencies (if that is what they are at all) are far less probative of Congress' intent than the unqualified and broad contingency provision.

Appellants insist that the use of "established by the State" in the premium tax credits calculation subprovision is evidence of Congress' intent to limit the availability of tax credits to consumers of state Exchange-purchased health insurance coverage. Their reading bespeaks a deeply flawed effort to squeeze the proverbial elephant into the proverbial mousehole. *Whitman v. American Trucking Associations*, 531 U.S. 457, 468 (2001). If Congress wanted to create a two-tiered Exchange system, it would have done so expressly in the section of the Act that authorizes the creation of contingent, federally-run Exchanges. If Congress wanted to limit the availability of premium tax credits to consumers who purchase health coverage on state-run Exchanges, it would have said so rather than tinkering with the formula in a subprovision governing how to calculate the amount of the credit.

The real danger in the Appellants' proposed interpretation of the Act is that it misses the forest for the trees by eliding Congress' central purpose in enacting the Act: to radically restructure the American health care market with "the most

expansive social legislation enacted in decades." Sheryl Gay Stolberg & Robert Pear, Obama Signs Health Care Overhaul Into Law, With a Flourish, N.Y. Times, March 24, 2010, at A19. The widespread availability of premium tax credits was intended as a critical part of the bill, a point the President highlighted at the bill signing. Transcript of Remarks by the President and Vice President at Signing of the Health Insurance Reform Bill, March 23, 2010 ("And when this exchange is up and running, millions of people will get tax breaks to help them afford coverage, which represents the largest middle-class tax cut for health care in history. That's what this reform is about."). Appellants' approach would effectively destroy the statute by promulgating a new rule that makes premium tax credits unavailable to consumers who purchased health coverage on federal Exchanges. But of course, as their counsel largely conceded at oral argument, that is their not so transparent purpose.

Appellants, citizens of the Commonwealth of Virginia, do not wish to buy health insurance. Most assuredly, they have the right, but not the unfettered right, *Nat'l Fed'n of Indep. Bus, v. Sebelius*, 132 S. Ct. 2566 (2012), to decline to do so. They have a clear choice, one afforded by the admittedly less-than-perfect representative process ordained by our constitutional structure: they can either pay the relatively minimal amounts needed to obtain health care insurance as provided by the Act, or they can refuse to pay and run the risk of incurring a tiny tax penalty. *Id.* What they may not do is rely on our help to deny to millions of Americans desperately-needed health insurance through a tortured, nonsensical construction of a federal statute whose manifest

purpose, as revealed by the wholeness and coherence of its text and structure, could not be more clear.

As elaborated in this separate opinion, I am pleased to concur in full in Judge Gregory's carefully reasoned opinion for the panel.

APPENDIX B

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

DAVID KING, *et al.*, Plaintiffs, v. KATHLEEN SEBELIUS, *et al.*, Defendants.	Civil Action No. 3:13-CV-630

MEMORANDUM OPINION

THIS MATTER is before the Court on a Motion for Summary Judgment filed by Plaintiffs (ECF No. 5) and a Motion to Dismiss filed by Defendants (ECP No. 30). Plaintiffs move the Court for Summary Judgment alleging that a regulation promulgated by the Internal Revenue Service ("IRS"), which extends eligibility for premium assistance subsidies[1] under the Patient Protection and Affordable Care Act ("ACA" or "Act") to individuals who purchase health coverage through federally-facilitated Exchanges, exceeds the IRS's statutory authority, is arbitrary and capricious, and is contrary to law in violation of

[1] The terms "tax credits," "premium assistance subsidies," and "premium assistance" are used interchangeably throughout this Memorandum Opinion.

the Administrative Procedure Act ("APA"), 5 U.S.C. § 706. Defendants in turn move the Court to dismiss Plaintiffs' Complaint and uphold the relevant regulation. For the reasons below, the Court will GRANT Defendants' Motion to Dismiss and DENY AS MOOT all remaining Motions.

I. STATUTORY AND FACTUAL BACKGROUND

A. Statutory Background

The ACA includes a series of measures intended to expand the availability of affordable health insurance coverage. These measures include: (1) the creation of health insurance exchanges ("Exchanges") that facilitate the purchase of insurance by individuals and small groups; (2) the availability of premium tax credits to assist individuals with the purchase of insurance on the Exchanges; and (3) the Minimum Coverage Provision, which requires most individuals either to maintain qualifying coverage or to pay a tax penalty for failure to do so. The IRS has also promulgated a regulation ("IRS Rule") that grants premium tax credits to individuals in all Exchanges, regardless of whether they are state-run or federally-facilitated.

1. The American Health Benefit Exchange System

The ACA creates health insurance Exchanges, organized along state lines, to serve as a marketplace for the purchase of health insurance by individuals and small businesses. *See* 42 U.S.C. § 18031(b)(1). The Exchanges are intended to help qualified individuals and small businesses "to benefit from the pooling of risk, market leverage, and economies of scale that large businesses currently enjoy." Centers

for Medicare & Medicaid Services, *Initial Guidance to States on Exchanges*, http://www.hhs.gov/cciio/resources/files/guidance_to_states_on_exchanges.html (last visited Feb. 3, 2014). In part, the Exchanges: (1) certify the qualified health plans offered on the Exchanges; (2) determine the eligibility of individuals to enroll in these qualified health plans; (3) determine the eligibility of individuals for advance payments of the ACA's premium tax credits and cost-sharing reductions; and (4) certify that individuals are exempt from the penalty under the Act's Minimum Coverage Provision. 42 U.S.C. §§ 18021(a)(1), 18022; 42 U.S.C. § 18031(d)(4); *see generally* 45 C.F.R. § 155.200.

Exchanges will offer plans providing different levels of coverage, designated as "bronze," "silver," "gold," and "platinum" coverage. 42 U.S.C. § 18022(d). A bronze level plan is the lowest level of coverage offered under 42 U.S.C. § 18022(d)(1). Exchanges may also offer "catastrophic" coverage plans. 42 U.S.C. § 18022(e); *see* 45 C.F.R. § 156.155. Enrollment in catastrophic coverage is limited to persons who are under 30 years of age, or for whom an Exchange has certified to be exempt from the Minimum Coverage Provision due to hardship or the lack of affordable insurance options. 42 U.S.C. § 18022(e); 45 C.F.R. § 156.155(a).

States may establish and operate these Exchange pursuant to 42 U.S.C., § 18031 ("Section 1311"), or the federal government may establish and operate an Exchange in place of the state where a state has chosen not to do so consistent with federal standards pursuant to 42 U.S.C. § 18041 ("Section 1321"). Thirty-four states, including Virginia, have decided

not to establish their own Exchanges pursuant to Section 1311. *See State Decisions for Creating Health Insurance Marketplaces*, Kaiser State Health Facts, http://kff.org/health-reform/state-indicator/health-insurance-Exchanges/ (last visited Feb. 3, 2014).

2. Premium Tax Credits

Among other incentives, the ACA provides premium tax credits under 26 U.S.C., § 36B ("section 36B") to help low and middle income individuals afford the cost of insurance purchased through the Exchanges. The Exchanges provide advance payments of premium tax credits directly to an eligible individual's insurer, thus lowering the net cost of insurance to the individual. 42 U.S.C. §118081-18082. The amount of premium assistance that an Exchange may provide for an eligible individual is based, in part, on the premium expenses for the health plan "enrolled in [by the individual] through an Exchange established by the State under [section] 1311." 26 U.S.C. § 36B(b)(2)(A). The amount of the premium tax credit available to a taxpayer under section 36B varies depending on the taxpayer's household income. However, premium tax credits are not available for the purchase of catastrophic coverage. 26 U.S.C. § 36B(c)(3)(A).

3. The Minimum Coverage Provision and Exemptions

Under the ACA's Minimum Coverage Provision, non-exempt individuals are required either to maintain a minimum level of health insurance or to pay a tax penalty. 26 U.S.C. § 5000A. This penalty in 2014 is one percent of an individual's yearly income or $95 for the year, whichever is higher, 26

U.S.C. § 5000A(c)(2)-(3), but it "cannot exceed the cost of the 'national average premium for qualified health plans' meeting a certain level of coverage." *Liberty Univ., Inc. v. Lew*, 733 F.3d 72, 84 (4th Cir. 2013) (quoting 26 U.S.C. § 5000A(c)(1)(B)). Certain individuals may be exempt from the mandate to maintain a minimum level of health insurance under 26 U.S.C. § 5000A(e). Among other exemptions, the Minimum Coverage Provision penalty does not apply to individuals who would need to contribute more than eight percent of their household income toward coverage. 26 U.S.C. § 5000A(e)(1)(A). The determination of an individual's household income toward coverage is calculated after taking into account any allowable section 36B premium tax credits. 26 U.S.C. § 5000A(e)(1)(B)(ii).

An individual who applies for an exemption and is denied may pursue an administrative appeal of that denial before a Department of Health and Human Services ("HHS") appeals entity. 42 U.S.C. § 18081(f). An appeal may be taken only after the applicant first exhausts any appeals that may be available in the Exchange. 45 C.F.R. §§ 155.505(b)(2), (c). This process is independent of the IRS's assessment of any penalty under the Minimum Coverage Provision. *See* 26 U.S.C. § 5000A(g).

4. The IRS Rule

The IRS Rule grants subsidies to anyone "enrolled in one or more qualified health plans through an Exchange." *See* Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377, 30,377-78, 30,387-89 (May 23, 2012); 26 C.F.R. § 1.36B-2(a)(1). The IRS Rule defines "Exchange" to mean "State Exchange,

regional Exchange, subsidiary Exchange, and Federally-facilitated Exchange." *Id.* at 30,378. According to IRS regulations, the term Exchange has "the same meaning as in 45 C.F.R. § 155.20." 26 C.F.R. § 1.36B-1(k). Finally, 45 C.F.R. § 155.20 defines Exchange to mean:

> a governmental agency or non-profit entity that meets the applicable standards of this part and makes [Qualified Health Plans] available to qualified individuals and/or qualified employers. *regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by HHS.*

45 C.F.R. § 155.20 (emphasis added). As such, individuals in federally-facilitated Exchanges are currently eligible for the premium tax credit under the IRS Rule.

B. **Factual Background**[2]

1. David King

David King ("King") was 63 years old on January 1, 2014; he is married with no dependents; he smokes tobacco products; and he has a projected household income of $39,000 for 2014. King is not eligible for government or employer-sponsored coverage, so the cheapest coverage available to him is the cheapest bronze coverage approved for sale to him on the

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[2] For the purposes of Defendants' Motion to Dismiss, the Court assumes all of Plaintiffs' well-pleaded allegations to be true, and views all facts in the light most favorable to Plaintiffs. *T.G. Slater & Son v. Donald P. & Patricia A. Brennan, LLC* 385 F.3d 836, 841 (4th Cir. 2004) (citing *Mylan Labs, Inc. v. Matkari*, 7 F.3d 1130, 1134 (4th Cir. 1993)); *see* Fed. R. Civ. P. 12(b)(6).

federal Exchange in Virginia. Because the cost of the cheapest bronze coverage approved for sale to King on the federally-facilitated Exchange in Virginia will exceed eight percent of King's projected household income for 2014, he would (absent any subsidy) be eligible for a certified exemption from the Minimum Coverage Provision penalty for 2014. King is, however, eligible for a subsidy that would bring him within the ambit of the Minimum Coverage Provision. King does not wish to comply with the Minimum Coverage Provision.

2. Douglas Hurst

Douglas Hurst ("Hurst") was 62 years old on January 1, 2014; he is married with no dependents; and he has a projected household income of $35,000 for 2014.[3] Hurst is not eligible for government or employer-sponsored coverage, so the cheapest coverage available to him is the cheapest bronze coverage approved for sale to him on the federally-facilitated Exchange in Virginia. Because the cost of the cheapest bronze coverage approved for sale to Hurst on the federally-facilitated Exchange in Virginia will exceed eight percent of Hurst's projected household income for 2014, he would (absent any subsidy) be eligible for a certified exemption from the Minimum Coverage Provision penalty for 2014. Hurst is, however, eligible for a subsidy that would bring him within the ambit of the Minimum Coverage Provision. Hurst does not want to comply with the Minimum Coverage Provision.

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[3] Due to counsel's error, the Complaint alleged the wrong figure.

3. Brenda Levy

Brenda Levy ("Levy") was 63 years old on January 1, 2014; she is single; and she has a projected household income of $43,000 for 2014, Levy is not eligible for government or employer-sponsored coverage, so the cheapest coverage available to her is the cheapest bronze coverage approved for sale to her on the federally-facilitated Exchange in Virginia. Because the cost of the cheapest bronze coverage approved for sale to Levy on the federally-facilitated Exchange in Virginia will exceed eight percent of Levy's projected household income for 2014, she would (absent any subsidy) be eligible for a certified exemption from the Minimum Coverage Provision penalty for 2014. Levy is, however, eligible for a subsidy that would bring her within the ambit of the Minimum Coverage Provision. Levy does not want to comply with the Minimum Coverage Provision.

4. Rose Luck

Rose Luck ("Luck") was 55 years old on January 1, 2014; she is married; she smokes tobacco products; and she has a projected household income of $45,000 for 2014. Luck is not eligible for government or employer-sponsored coverage, so the cheapest coverage available to her is the cheapest bronze coverage approved for sale to her on the federal Exchange in Virginia. Because the cost of the cheapest bronze coverage approved for sale to Luck on the federally-facilitated Exchange in Virginia will exceed eight percent of Luck's projected household income for 2014, she would (absent any subsidy) be eligible for a certified exemption from the Minimum Coverage Provision penalty for 2014. Luck is, however, eligible for a subsidy that would bring her

within the ambit of the Minimum Coverage Provision. Luck does not want to comply with the Minimum Coverage Provision.

II. LEGAL STANDARD

Rule 12 of the Federal Rules of Civil Procedure allows a defendant to raise a number of defenses to a complaint at the pleading stage, including failure to state a claim. A motion to dismiss for failure to state a claim upon which relief can be granted challenges the legal sufficiency of a claim, rather than the facts supporting it. Fed. R. Civ. P. 12(b)(6); *Goodman v. Praxair, Inc.*, 494 F.3d 458, 464 (4th Cir. 2007); *Republican Party of N.C. v. Martin*, 980 F.2d 943, 952 (4th Cir. 1992). A court ruling on a Rule 12(b)(6) motion must accept all of the factual allegations in the complaint as true, *see Edwards v. City of Goldsboro*, 178 F.3d 231, 244 (4th Cir. 1999); *Warner v. Buck Creek Nursery, Inc.*, 149 F. Supp. 2d 246, 254-55 (W.D. Va. 2001), in addition to any provable facts consistent with those allegations, *Hishon v. King & Spalding*, 467 U.S. 69, 73 (1984), and must view these facts in the light most favorable to the plaintiff, *Christopher v. Harbury*, 536 U.S. 403, 406 (2002).

To survive a motion to dismiss, a complaint must contain factual allegations sufficient to provide the defendant with "notice of what the claim is and the grounds upon which it rests." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007) (quoting *Conley v. Gibson*, 355 U.S. 41, 47 (1957)). Rule 8(a)(2) requires the complaint to allege facts showing that the plaintiff's claim is plausible, and these "[f]actual allegations must be enough to raise a right to relief above the speculative level." *Twombly*, 550 U.S. at

555 & n.3. The Court need not accept legal conclusions that are presented as factual allegations, *id.* at 555, or "unwarranted inferences, unreasonable conclusions, or arguments," *E. Shore Mkts., Inc. v. J.D. Assocs. Ltd. P'ship*, 213 F.3d 175, 180 (4th Cir. 2000).

III. ANALYSIS

A. Justiciability

1. Standing

The doctrine of standing is comprised of two analytical strains. *See Elk Grove Unified Sch. Dist. v. Newdow*, 542 U.S. 1, 11 (2004). The first regards Constitutional limitations on the Court's adjudicative capacity and is rooted firmly in Article III. There, the judicial power of the United States is said to extend only to a limited class of "cases" and "controversies." U.S. Const. art. III, § 2. To establish Article III standing, it must be shown: (1) that the plaintiff suffered the invasion of a legally protected interest; (2) that there is a fairly traceable causal connection between the injury alleged and the conduct challenged; and (3) that there is a reasonable likelihood that the injury alleged could be redressed by a favorable decision from the court. *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992). "[T]hreatened injury must be certainly impending to constitute injury in fact," and "[a]llegations of possible future injury" are not sufficient. *Clapper v. Amnesty Int'l USA*, 133 S. Ct. 1138, 1141 (2013) (quotation marks omitted) (quoting *Whitmore v. Arkansas*, 495 U.S. 149, 158 (1990)).

There is also prudential standing where "[t]he interest [a person] asserts must be arguably within the zone of interests to be protected or regulated by

the statute' that he says was violated." *Match-E-Be-Nash-She-Wish Band of Pottawatomi Indians v. Patchak*, 132 S. Ct. 2199, 2210 (2012) (quoting *Assoc. of Data Processing Serv. Orgs., Inc. v. Camp*, 397 U.S. 150, 153 (1970)); *see also Taubman Realty Grp. Ltd. P'ship v. Mineta*, 320 F.3d 475, 480 (4th Cir. 2003). This test is not especially demanding, and any benefit of the doubt goes to the plaintiff. *Patchak*, 123 S. Ct. at 2210. "[T]his inquiry must be determined not by reference to the overall purpose of the statute in question but, instead, by reference to the particular provision(s) of law upon which the plaintiff seeks redress." *Mineta*, 320 F.3d at 480 (citations omitted); *see also Bennett v. Spear*, 520 U.S. 154, 175-76 (1997). "The test forecloses suit only when a plaintiff's 'interests are so marginally related to or inconsistent with the purposes implicit in the statute that it cannot reasonably be assumed that Congress intended to permit the suit.'" *Patchak*, 132 S. Ct. at 2210; *TAP Pharm. v. U.S. Dep't of Health & Human Servs.*, 163 F.3d 199, 203 (4th Cir. 1998).

a. Article III Standing

Defendants assert that Plaintiffs cannot establish standing because they are not being economically injured by the IRS Rule. Instead, they characterize Plaintiffs' actions as the rejection of a benefit in an attempt to manufacture harm where there is none. Plaintiffs assert that they are harmed economically because the IRS Rule denies them an exemption from the Minimum Coverage Provision and, thus, the option not to buy any health insurance at all. Plaintiffs argue that, as a result of the IRS Rule, they will incur some financial cost because they will be forced to buy insurance or pay the Minimum

Coverage Provision penalty. In the alternative, Plaintiffs also assert that being forced to buy insurance and having to contact insurers are cognizable Article III injuries.

The Court assumes that "the merits of a dispute will be resolved in favor of the party invoking jurisdiction in assessing standing and, at the pleading stage, 'presumes that general allegations embrace those specific facts that are necessary to support the claim.'" *Equity In Athletics, Inc. v. Dep't of Educ.*, 639 F.3d 91, 99 (4th Cir. 2011) (quoting *Lujan v. National Wildlife Federation*, 497 U.S. 871, 889 (1990)). It follows that Plaintiffs have standing because their economic injury is real and traceable to the IRS Rule. *Halbig v. Sebelius*, No. CV 13-0623 (PLF), 2014 WL 129023, at *6 (D.D.C. Jan. 15, 2014). Lastly, Plaintiffs clearly meet the third prong of the standing doctrine because this Court has the power to redress their injuries by invalidating the IRS Rule.[4]

b. Prudential Standing

The prudential standing doctrine has been stated in many different forms and iterations. Under Fourth Circuit jurisprudence, the relevant focus is on the particular provision of the law upon which the plaintiff seeks redress. *See Syngenta Crop Prot., Inc. v. EPA*, No. 1:02-CV-334, 2011 WL 3472635, at *7-8 (M.D.N.C. Aug. 9, 2011) (citing *Mineta*, 320 F.3d at

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[4] To the extent that Plaintiffs assert that they are being injured as taxpayers because the IRS Rule improperly allowed the outlay of billions of dollars in tax credits, their argument fails. *See Howard v. 111th U.S. Cong.*, No. 2:09-CV-25, 2009 WL 1704421, at *3 (W.D.N.C. June 12, 2009).

480). To determine whether a plaintiff's interests are within the zone of interests to be protected, the court must "first discern the interests 'arguably to be protected' by the statutory provision at issue" and "then inquire whether the plaintiff's interests affected by the agency action in question are among them." *TAP Pharm.*, 163 F.3d at 203 (quoting *Nat'l Credit Union Admin. v. First Nat'l Bank & Trust Co.*, 522 U.S. 479, 492 (1998)).

Plaintiffs bring suit under the APA to invalidate the IRS Rule. (*See* Compl. ¶¶ 8, 40). The ostensible purpose of section 36B is "[t]o ensure that health coverage is affordable," and "to help offset the cost of private health insurance premiums." S. Rep. No. 111-89, at 4 (2009); *see also* H. Rep. No. 111-443, vol. II, at 977 (2010). Finally, the IRS Rule pertains to eligibility of individuals for a tax credit under section 36B, as an integral component to the ACA.

Plaintiffs are directly regulated by section 36B and, thus, the IRS Rule interpreting it, because they are "applicable taxpayers" under the section. As taxpayers that are eligible for tax subsidies under section 36B, Plaintiffs' interests are affected by the IRS Rule. The Supreme Court has explicitly stated that the test is not meant to be especially demanding and that any benefit of doubt should go to the plaintiff. *Patchak*, 123 S. Ct. at 2210. It would be a stretch of the imagination to assert that Plaintiffs' "interests are so marginally related to or inconsistent with the purposes implicit in the statute that it cannot reasonably be assumed that Congress intended to permit the suit." *Id.* As such, Plaintiffs have prudential standing.

2. The Administrative Procedure Act and the Tax Refund Alternative

Defendants characterize Plaintiffs' claim as seeking relief that would declare that they have no potential tax liability for 2014 under the Minimum Coverage Provision. They argue that this matter is effectively a tax liability suit and that Plaintiffs must comply with the tax refund scheme under 26 U.S.C. § 7422 and challenge the tax under the Tucker Act, 28 U.S.C. § 1346(a). In response, Plaintiffs argue that they should be able to bring suit under the APA and that a post-enforcement tax liability suit is an after-the-fact remedy that is not an "adequate" alternative to a pre-enforcement injunctive suit under the APA.

Plaintiffs have the better of these arguments because "the tax refund mechanism is inferior to an APA suit and fails to provide complete relief to these plaintiffs." *Halbig*, 2014 WL 129023, at *7. While a tax refund suit would provide an adequate judicial remedy in some ways, it is inferior to an APA suit because it fails to provide complete relief to these plaintiffs. "Relegating plaintiffs' claims to a tax refund action would force plaintiffs to make a choice between purchasing insurance, thereby waiving their claims, or foregoing insurance and incurring the tax penalty, which they will recover much later, and only if they prevail. They also will be deprived of the opportunity to obtain prospective certificates of exemption." *Id.* Further, an "administrative challenge would be futile, as the Secretary of the Treasury can be expected to deny plaintiffs' complaint as contrary to the issued IRS regulations." *Id.*

Moreover, Plaintiffs' claim is not a tax liability suit. In a similar case, *Hobby Lobby Stores, Incorporated v. Sebelius*, corporations sought to enjoin the enforcement of an HHS regulation that required them to provide their employees with health plans that included preventative care. 723 F.3d 1114, 1127 (10th Cir. 2013). The Tenth Circuit held that the corporation's suit was not "challenging the IRS's ability to collect taxes. Rather, they [sought] to enjoin the enforcement of one HHS regulation." *Id.*; *see also Halbig*, 2014 WL 129023, at *8. Similarly, here Plaintiffs are challenging the IRS Rule and not the IRS's ability to collect taxes.[5]

3. Ripeness

"A claim should be dismissed as unripe if the plaintiff has not yet suffered injury and any future impact 'remains wholly speculative.'" *Doe v. Va. Dep't of State Police*, 713 F.3d 745, 758-59 (4th Cir. 2013) (quoting *Gasner v. Bd. of Supervisors*, 103 F.3d 351, 361 (4th Cir. 1996)). Determining whether administrative action is ripe for judicial review requires courts to evaluate and balance (1) the fitness of the issues for judicial decision and (2) the hardship to the parties of withholding court consideration. *Nat'l Park Hospitality Ass'n v. Dep't of Interior*, 538 U.S. 803, 808 (2003). "A case is fit for judicial decision when the issues are purely legal and when the action in controversy is final and not dependent on future uncertainties." *Doe*, 713 F.3d at 758

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[5] It is clear that the Anti-Injunction Act does not preclude Plaintiffs from brining suit for the purpose of avoiding a potential tax penalty under the Minimum Coverage Provision. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2583-84 (2012).

(quoting *Miller v. Brown*, 462 F.3d 312, 319 (4th Cir. 2006)). The fitness prong prevents a court from considering a controversy until it is presented in "clean and concrete form." *Id.* (citing *Rescue Army v. Mun. Ct. of Los Angeles*, 331 U.S. 549, 584 (1947)). The hardship prong is measured by the immediacy of the threat and the burden imposed on the plaintiff. *Id.*; *Lansdowne on the Potomac Homeowners Ass'n, Inc, v. OpenBand at Lansdowne, LLC*, 713 F.3d 187, 199 (4th Cir. 2013). In considering the hardship to be balanced against the fitness of the issues for review, a court may consider the cost to the plaintiff of delaying review. *Doe*, 713 F.3d at 758; *see also id.* at 759.

a. Fitness for Review

Defendants assert that even if Plaintiffs had standing, the suit is not ripe because the IRS has not yet applied its regulation to Plaintiffs' circumstances. Defendants argue that this matter is not fit for resolution because the Court cannot determine Plaintiffs' potential liability for the tax penalty under the Minimum Coverage Provision. Instead, they assert that Plaintiffs' claims will be ripe after they are taxed because they can then bring a refund action. Plaintiffs reply by arguing this action is presumptively reviewable and ripe because it is a purely legal claim in the context of a facial challenge to the IRS Rule.

Plaintiffs' claim is more accurately described as a broad-based attack on an entire regulatory scheme rather than one based on the possibilities of a particularized application. *See Appalachian Power Co. v. Train*, 566 F.2d 451, 458 (4th Cir. 1977) ("If the regulations are alleged to be invalid as written, we

think they must be reviewed expeditiously if the challenge is simply to the manner in which the regulations may be applied in a [ ] proceeding, then the proper time for review would be on appeal from the issuance or denial ").

In *Hodel v. Virginia Surface Mining & Reclamation Association*, the Supreme Court illustrated the difference between general questions that may be ripe for decision upon enactment of a challenged statute and more specific questions that must await concrete applications. 452 U.S. 264, 294-97 (1981). In *Hodel*, the Supreme Court found ripe, and rejected, a facial challenge to the Surface Mining Control & Reclamation Act of 1977. *Id.* at 295-97. However, it found that more specific claims of uncompensated takings of land were not ripe for review because their determination rested on valuation, estimates of economic impact, and other factual inquiries regarding particular property. *Id.* at 296-97. Similarly, in *Public Utilities Commission of the State of California v. United States*, the United States argued that California could not require common carriers to obtain Commission approval before agreeing to carry government shipments at negotiated rates. 355 U.S. 534, 538-39 (1958). The Supreme Court found the Government's claim ripe and upheld the claim before any actual application of the administrative procedure at issue. *Id.* at 539.

As stated previously, Plaintiffs will suffer harm as a result of the IRS Rule because they would be subject to the Minimum Coverage Provision penalty or would be forced to buy insurance that they do not want. While the Plaintiffs in this matter are each unique, for the purposes of standing, the Complaint

seeks to invalidate the IRS Rule as a whole.[6] Plaintiffs are challenging the facial validity of the IRS Rule, which is a final agency rule that is beginning to affect individuals, including Plaintiffs. *Halbig*, 2014 WL 129023, at *7. As such, Plaintiffs' claim is fit for review.

b. Hardship Determination

Plaintiffs' claims are within the ambit of clearly defined Fourth Circuit precedent under *Arch Mineral Corporation v. Babbitt* and other similar cases. *See, e.g., Arch Mineral Corp. v. Babbitt*, 104 F.3d 660 (4th Cir. 1997). In *Arch Mineral Corporation*, a corporation allegedly owed fees and penalties to the Office of Surface Mining Reclamation and Enforcement ("OSM") because it purchased a mine that was delinquent and abandoned. *Id.* at 662. The corporation's liability was based on an ownership or control rule that had yet to proceed through all of OSM's administrative channels. *Id.* at 666. After receiving letters from OSM declaring liability based a presumed link between the corporation and a seller, the corporation sued for injunctive and declaratory relief. *Id.* OSM argued that the case was not ripe because it had not decided as to whether to bring an enforcement action against the corporation. *Id.* at 665-66. However, the Ninth Circuit determined that, for multiple reasons, there was little doubt that OSM intended to enter the corporation into the

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[6] Defendants also contend that, to the extent that Plaintiffs seek a certificate of exemption, this Court is not empowered to award such an exemption because Plaintiffs must apply to the Virginia Exchange for that certificate. Defendants' argument is inapposite because this opinion is not in any way a determination of the validity of Plaintiffs' specific applications.

applicant/violator system in the immediate future. *Id.* at 666. Thus, the corporation was faced with a "Hobson's choice" of being listed on an applicant/violator system or paying the relevant penalties and suing for a refund. *Id.* at 669 n.2.

In this instance, Plaintiffs risk impending hardship because they face the certainty of either incurring the cost of buying insurance or paying the penalty pursuant to a violation of the Minimum Coverage Provision. *See Atl. Marine Corps Cmtys., LLC v. Onslow Cnty., N.C.*, 497 F. Supp. 2d 743, 749 (E.D.N.C. 2007) ("There is no doubt that injury to plaintiff is more than a mere potentiality and that if defendants prevail in this action they will immediately proceed to tax the properties. No further factual development is necessary, and withholding judicial consideration would cause hardship to the parties and would serve no useful purpose."). This choice is immediate because Plaintiffs must apply for an exemption in the Virginia Exchange in early 2014. Even assuming that the financial burden imposed on Plaintiffs is slight, at least some hardship is present. Moreover, Plaintiffs are challenging the IRS Rule, which is a final agency rule that is beginning to adversely affect individuals, including Plaintiffs. As such, this matter is ripe for review. *See Halbig*, 2014 WL 129023, at *7.

B. Statutory Interpretation

"*Chevron* deference is a tool of statutory construction whereby courts are instructed to defer to the reasonable interpretations of expert agencies charged by Congress to fill any gap left, implicitly or explicitly, in the statutes they administer." *Nat'l*

Elec. Mfrs. Ass'n v. U.S. Dep't of Energy, 654 F.3d 496, 504 (4th Cir. 2011) (quoting *Am. Online, Inc. v. AT&T Corp.*, 243 F.3d 812, 817 (4th Cir. 2001)) (internal quotation marks and alterations omitted). *Chevron* deference requires a court to undertake a two-part analysis to review an agency's regulation. *Chevron U.S.A., Inc. v. Natural Res Def. Council, Inc.*, 467 U.S. 837 (1984). At the first step, a court must look to the "plain meaning" of the statute and determine if the regulation responds to it. *Id.* at 837, 842-43. If it does, the inquiry need not continue. *Id.* At the second step, if the statute is silent or ambiguous, a court must determine whether a given regulation is a permissible construction. *Id.* at 843; *Nat'l Elec. Mfrs. Ass'n*, 654 F.3d at 504.

1. *Chevron* Step One

Under *Chevron*, if a statute is unambiguous regarding the question presented, the statute's plain meaning controls. *Morgan v. Sebelius*, 694 F.3d 535, 537 (4th Cir. 2012). In order to be ambiguous, disputed language must be "reasonably susceptible of different interpretations." *Nat'l R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 473 n.27 (1985). At the first step of *Chevron*, a court may also employ traditional tools of statutory construction to ascertain whether Congress has expressed its intent regarding the precise question at issue. *Chevron*, 467 U.S. at 843 n.9; *Nat'l Elec. Mfrs. Ass'n*, 654 F.3d at 504.

a. The Meaning of "Exchange" as Used in Section 36B

The statutory provision that authorizes premium tax credits provides that "[i]n the case of an applicable taxpayer, there shall be allowed as a credit

against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year." 26 U.S.C. § 36B(a). Section 36B(b)(2) states that the premium assistance amount determined under the subsection with respect to any coverage month is the amount equal to the lesser of

> (A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under [section] 1311 of the Patient Protection and Affordable Care Act, or
>
> (B) The excess (if any) of—
> (i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over
> (ii) an amount equal to $1/12$ of the product of the applicable percentage and the taxpayer's household income for the taxable year.

26 U.S.C. § 36B(b)(2). The term "Exchange" is not defined in section 36B. *See* 26 U.S.C. § 36B.

Plaintiffs assert that the text of section 36B is unambiguous and that the plain meaning of the phrase "established by the State under [section] 1311," in section 36B(b)(2)(A) indicates that Congress intended to refer exclusively to state Exchanges, as opposed to federally-facilitated Exchanges. In essence, Plaintiffs' theory is that: (1) state and federally-facilitated Exchanges are referred to

separately under Section 1311 and Section 1321; (2) section 36B(b)(2)(A) refers solely to Section 1311 when addressing tax subsidies; (3) the omission of any mention of Exchanges under 1321 in section 36B(b)(2)(A) was intentional; and (4) the ACA sometimes refers generically to "an Exchange" or "an Exchange established under this Act" in other provisions. Defendants argue that the word "Exchange" necessarily means "Exchange established under [section] 1311" regardless of whether the Exchange is run by a state or is federally-facilitated.

At first blush, each party presents seemingly credible constructions of the language in section 36B. Viewed in a vacuum, it seems comprehensible that the omission of any mention of federally-facilitated Exchanges under section 36B(b)(2)(A) could imply that Congress intended to preclude individuals in federally-facilitated Exchanges from receiving tax subsidies. However, when statutory context is taken into account, Plaintiffs' position is revealed as implausible.

b. Plaintiffs' Reading and the Resulting Anomalies in the ACA

Courts have a duty to construe statutes as a whole. *See, e.g., Graham Cnty. Soil & Water Conservation Dist. v. United States ex rel. Wilson*, 559 U.S. 280, 290 (2010). Plaintiffs essentially assert that Congress struck a bargain in which it decided to favor state-run Exchanges and contemplated that participants in federally-facilitated Exchanges would not receive tax credits. Plaintiffs aver that Congress's bargain backfired when, to the surprise of all, many states did not opt to create and run their own Exchanges. As such, Plaintiffs fundamentally

contend that, to the extent that their reading of section 36B harms the implementation of the ACA, any adverse consequences are the result of a miscalculation by Congress. In contrast, Defendants argue that their interpretation of section 36B is correct because it furthers Congress's intent to provide affordable health insurance for all. Defendants support their argument, in part, by setting forth numerous statutory anomalies that Plaintiffs' reading would incur. Plaintiffs attempt to mitigate these anomalies by either declaring that they do not matter or that they are minimally disruptive to the implementation of the ACA.

As a threshold matter, the ACA provides that if a State has not established its own Exchange by January 1, 2014, the Secretary of the HHS will create "'such Exchange' – that is, by definition under the statute, 'an American Health Benefit Exchange established under [section 1311].'" *Halbig*, 2014 WL 129023, at *13 (quoting 42 U.S.C. § 18041(c); 42 U.S.C. § 300gg-91(d)(21)). Plaintiffs' reading of section 36B grows even weaker when other sections of the ACA are taken into account. So as not to belabor the point, the Court will address the more anomalous results of Plaintiffs' reading of section 36B at length and simply refer in passing to other provisions.

i. The Eligibility Provision

Section 1312 of the ACA sets forth provisions regarding which individuals may purchase insurance from the Exchanges. 42 U.S.C. § 18032. Under Section 1312(a)(1), eligible individuals may enroll in any qualified plan to which they are eligible. However, Defendants note that part of the definition

of the term "qualified individual" requires that the individual reside in a State that establishes an Exchange under Section 1311 ("Residency Requirement"). *See* 42 U.S.C. § 18032(f)(1)(A)(ii). As such, Defendants aver that, under Plaintiffs' reading of section 36B, no person in a state with a federally-facilitated Exchange could become a "qualified individual."

First, Plaintiffs argue that as a result of the failure of states to establish their own Exchanges, it is natural that individuals living in states with federally-facilitated Exchanges would be ineligible because the eligibility provision only applies to state-run Exchanges under Section 1311. Second, they aver that, even if the eligibility provision is read to apply to persons in federally-facilitated Exchanges, the Residency Requirement should be construed as inapplicable to people in states with federally-facilitated Exchanges.

Plaintiffs' insistence that the Court should read the Residency Requirement out of the ACA or not apply Section 1312 to federally-facilitated Exchanges is a telltale sign that their reading of section 36B is wrong.[7] If construed literally, the eligibility provision would be nullified when applied to states with federally-facilitated Exchanges, rendering the provision superfluous.

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[7] Various other provisions of the ACA also reflect an assumption that a state Exchange under Section 1311 exists in each state. *See, e.g.*, 42 U.S.C. § 1396a(gg); 42 U.S.C. § 1397ee(d)(3)(B).

ii. Reporting Requirements Under Section 36B(f)(3)

Section 36B(f)(3) directs: "[e]ach Exchange (or any person carrying out 1 or more responsibilities of an Exchange under section 1311(f)(3) or 1321(c) of the Patient Protection and Affordable Care Act)" to provide certain information to the Secretary and to the taxpayer with respect to any health plan provided through the Exchange including:

(A) The level of coverage described in section 1302(d) of the Patient Protection and Affordable Care Act and the period such coverage was in effect.
(B) The total premium for the coverage without regard to the credit under this section or cost-sharing reductions under section 1402 of such Act.
(C) The aggregate amount of any advance payment of such credit or reductions under section 1412 of such Act.
(D) The name, address, and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy.
(E) Any information provided to the Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of, such credit.
(F) Information necessary to determine whether a taxpayer has received excess advance payments.

26 U.S.C. § 36B(f)(3).

Defendants assert that under Plaintiffs' reading, federally-facilitated Exchanges would perform an "empty act" because they would have to report the aggregate amount of any advance payment of subsidies as zero, and would not have to report any individualized information necessary to determine eligibility for subsidies. Plaintiffs counter with a collective "so what?" (Pls.' Opp'n Mot. Dismiss 10, 12). They aver, without support, that this provision is an example of sensible draftsmanship because otherwise Congress would have had to draft separate sections detailing reporting requirements.

Plaintiffs' explanations are unpersuasive. Under their interpretation, section 36B(f) would be superfluous with respect to federally-facilitated Exchanges under Section 1321 because such Exchanges would not be authorized to deliver tax credits. "Section 36B(f) thus indicates that Congress assumed that premium tax credits would be available on any Exchange, regardless of whether it is operated by a state under [Section 1311] or by HHS under [Section 1321]." *Halbig*, 2014 WL 129023, at *15.

iii. Medicaid "Maintenance Efforts" and Clear Notice

Under the ACA, participating states shall maintain their then-existing eligibility standards, until the effective date of the ACA's Medicaid eligibility expansion provisions. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). This "maintenance of effort" provision directs states, as a condition for the receipt of federal Medicaid funds, not to impose any "eligibility standards, methodologies, or procedures" under their Medicaid state plan, or any applicable waivers, that are more restrictive than the standards

that the state had in place as of the date the ACA was enacted. 42 U.S.C. § 1396a(gg)(1). This condition applies until "the date on which the Secretary determines that an Exchange established by the State under [Section 1311] is fully operational." *Id.* Under Plaintiffs' reading of section 36B, a state with a federally-facilitated Exchange would *never* be relieved of this maintenance of effort requirement. Specifically, under Plaintiffs' reading, states would be obligated by the ACA to maintain their Medicaid program in its current form indefinitely because federally-facilitated Exchanges would never be "fully operational" under Section 1311. Therefore, the HHS Secretary would never be able to release the "condition." This would mean that state's Medicaid programs would be frozen until they opted to create their own state-run Exchange under Section 1311, effectively forcing the states to take action.

Pursuant to the "*Arlington* rule," the federal government must provide clear notice before it uses its Spending Clause powers to impose substantive conditions or obligations on States that they would not otherwise be required by law to observe. *Arlington Cent. Sch. Dist. Bd. of Ed. v. Murphy*, 548 U.S. 291, 298 (2006). "The reason for requiring notice is simple: States cannot knowingly accept conditions of which they are unaware or which they are unable to ascertain." *Sossamon v. Texas*, 131 S. Ct. 1651, 1664 (2011) (quoting *Arlington Cent. Sch. Dist. Bd. of Ed.*, 548 U.S. at 296) (internal quotation marks omitted).

Plaintiffs cite to various examples of the federal government conditioning funds on desired actions (or

as Plaintiffs put it, "a too good to turn down" offer). (Pls.' Opp'n Mot. Dismiss 22). However, Defendants' argument based on the Medicaid "maintenance of effort" is fundamentally different from one regarding the mere conditioning of federal funds on desired actions. As Defendants suggest, this potential condition on state's power over their Medicaid programs could be unconstitutional under any number of legal arguments including the *Arlington* rule. This anomalous consequence of Plaintiffs' reading of the ACA and section 36B indicates that Plaintiffs' interpretation is wrong.[8]

c. Congressional Intent and Legislative History

In an attempt to divine Congress's intent, both parties cite to various legislative history materials including, but not limited to, past versions of the ACA, committee reports, reports by the Congressional Budget Office ("CBO") and Joint Committee on Taxation ("JCT"), and finally, even news media. It is firmly established that legislative history is one of the traditional tools of interpretation to be consulted at *Chevron*'s step one. *Morgan*, 694

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[8] Other persuasive anomalies arise under other sections including, but not limited to, 42 U.S.C. § 1397ee(d)(3)(C) (regarding children's health insurance plans); 42 U.S.C. § 18031(d)(4)(G) (regarding the creation of an electronic calculator to determine compare the cost of different coverage options); 42 U.S.C. § 18031(d)(4)(I) (regarding information transmission to the IRS); 42 U.S.C. § 18083 (relating to applications made redundant or useless); 42 U.S.C. § 1397ee(d)(3)(B) (requiring HHS to determine, for each state, whether health plans offered through "an Exchange established by the State under [section 1311]" provide benefits for children comparable to those offered in the state's CHIP plan).

F.3d at 538-39; *see also Nat'l Elec. Mfrs. Ass'n*, 654 F.3d at 504-05.

The legislative history of the ACA is long and complex, and many of the past versions of the ACA are not relevant to the current iteration of the ACA. *See generally* John Cannan, *A Legislative History of the Affordable Care Act: How Legislative Procedure Shapes Legislative History*, 105 Law Libr. J. 131, 136 (2013). The very structure of the ACA indicates that "the Senate passed a bill that provided 'flexibility' to each state as to whether it would operate the Exchange." *Halbig*, 2014 WL 129023, at *17 (citing 42 U.S.C. § 18041). The relevant legislative history indicates that Congress did not expect the states to turn down federal funds and fail to create and run their own Exchanges. Instead, Congress assumed that tax credits would be available nationwide because every state would set up its own Exchange. *See, e.g.*, CBO, An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act (Nov. 30, 2009) (discussing Exchanges generally when calculating anticipated subsidies across all states); Letter from Douglas W. Elmendorf, Director, CBO, to Rep. Darrell Issa, Chairman, House Comm. on Oversight & Gov't Reform (Dec. 6, 2012) ("To the best of our recollection, the possibility that those subsidies would only be available in states that created their own exchanges did not arise during the discussions CBO staff had with a wide range of Congressional staff when the legislation was being considered.").

What *is* clear is that there is no direct support in the legislative history of the ACA for Plaintiffs' theory that Congress intended to condition federal

funds on state participation. *Halbig*, 2014 WL 129023, at *16 (holding that there is no evidence in the legislative record that the House, the Senate, any relevant committee of either House, or any legislator ever entertained the idea of conditioning federal tax credits upon state participation in the creation of the Exchanges). As previously discussed, had Congress intended to condition tax subsidies it would have needed to provide clear notice. While on the surface, Plaintiffs' plain meaning interpretation of section 36B has a certain common sense appeal, the lack of any support in the legislative history of the ACA indicates that it is not a viable theory. The legislative history of the ACA "reveals an intent to grant states the option of establishing their own Exchanges, rather than an intent to coerce or entice states into participating." *Halbig*, 2014 WL 129023, at *17. Further, the text of the ACA and its legislative history evidence congressional intent to ensure broad access to affordable health coverage for all. *See, e.g.*, 42 .S.C. § 18091(2)(D)-(G); S. Rep. No. 111-89, at 4; *see also* H.R. Rep. No. 111-443, vol. II, at 977.

2. *Chevron* Step Two and Statutory Interpretation

Assuming for the sake of argument that the text of section 36B is ambiguous, Plaintiffs' arguments fail at *Chevron* step two. *Chevron* deference is afforded only when an "agency's interpretation is rendered in the exercise of [its] authority [to make rules carrying the force of law]." *A.T. Massey Coal Co. v. Barnhart*, 472 F.3d 148, 166 (4th Cir. 2006) (citing *United States v. Mead Corp.*, 533 U.S. 218, 226-27 (2001)). Defendants assert that the HHS and

IRS should receive *Chevron* deference in their interpretation of section 36B and the ACA because the ACA is a "shared-administration" statute and both HHS and the Department of the Treasury are in full agreement about how to interpret the word "Exchanges" within the context of section 36B.

The ACA is a type of shared administration statute in which the HHS and Department of the Treasury perform different functions. Each agency has specifically defined authority.[9] Under section 36B(g), Congress charged the Department of the Treasury with prescribing "such regulations as may be necessary to carry out the provisions of this section." 26 U.S.C. § 36B(g). Under Section 1321(a)(1), Congress charged HHS with setting the standards for meeting the requirements of the section regarding the operation and enforcement of Exchanges and related requirements. 42 U.S.C. § 18041(a)(1). The Department of the Treasury and HHS, however, share some joint responsibility for administering parts of the Act regarding implementation of the tax credit scheme. *See* 42 U.S.C. § 18082(a) ("The Secretary [of HHS], in consultation with the Secretary of the Treasury, shall establish a program under which" advance determinations and payments of tax credits are made.). The two agencies "work in close coordination to release guidance related to Exchanges," and HHS has promulgated its own regulations providing

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[9] In fact, the ACA contains more than forty provisions that require, permit, or contemplate rulemaking authority by federal agencies. *See* CBO, Regulations Pursuant to the Patient Protection and Affordable Care Act (P.L. 111-148) (April 13, 2010).

that participants on both state and federally-facilitated Exchanges are eligible for advance payments of the credits. *See* 45 C.F.R. § 155.20; Health Insurance Premium Tax Credit, 76 Fed. Reg. 50,931-32 (Aug. 17, 2011). The IRS has imported HHS's definition of "Exchange" into the IRS Rule. *See* 26 C.F.R. § 1.36B-1(k).

In *Collins v. National Transportation Safety Board*, the D.C. Circuit explained that there are three types of shared-enforcement statutes: (1) generic statutes that have "broadly sprawling applicability [that] undermines any basis for deference"; (2) "statutes where agencies have specialized enforcement responsibilities but their authority potentially overlaps—thus creating risks of inconsistency or uncertainty"; and (3) "statutes where expert enforcement agencies have mutually exclusive authority over separate sets of regulated persons." 351 F.3d 1246, 1253 (D.C. Cir. 2003). For the most part, the HHS and the Department of the Treasury have mutually exclusive authority under the ACA. Such authority "does not work against the application of *Chevron* deference." *Id.* Accordingly, the IRS is afforded *Chevron* deference in its interpretation of section 36B. Additionally, the HHS is afforded *Chevron* deference in its interpretation of the ACA. Moreover, in cases where "the subject matter of the statute falls squarely within the agencies' areas of expertise, and the Regulations were issued as a result of a statutorily coordinated effort among the agencies, *Chevron* is the governing standard." *Halbig*, 2014 WL 129023, at *12 (quoting *Individual Reference Servs. Grp., Inc. v. FTC*, 145 F. Supp. 2d 6, 24 (D.D.C. 2001), *aff'd, Trans Union LLC v. FTC*, 295 F.3d 42 (D.C. Cir. 2002)). As such,

Chevron deference applies here, where both the HHS and the Department of the Treasury, through the IRS, have coordinated and created a consistent definition of "Exchange" as it applies to the IRS Rule and related HHS regulations.

Even if this Court assumes that Plaintiffs' interpretation of the ACA, section 36B, and related HHS regulations is reasonable, Plaintiffs have not met their burden to show that Defendants' contrary reading is unreasonable. In light of the applicable legislative history of the ACA and the above discussion of the anomalous consequences of Plaintiffs' reading of the ACA, Defendants at the very least have presented a reasonable interpretation of HHS's regulations and, thus, section 36B.

IV. CONCLUSION

For the above reasons, Defendants' Motion to Dismiss will be GRANTED. All remaining Motions will be DENIED AS MOOT.

Let the Clerk send a copy of this Memorandum Opinion to all counsel of record.

An appropriate Order shall issue.

/s/

James R. Spencer
United States District Judge

ENTERED this 18th day of February 2014.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

DAVID KING, *et al.*, Plaintiffs, v. KATHLEEN SEBELIUS, *et al.*, Defendants.	Civil Action No. 3:13-CV-630

ORDER

THIS MATTER is before the Court on a Motion for Summary Judgment filed by Plaintiffs (ECF No. 5) and a Motion to Dismiss filed by Defendants (ECF No. 30). For the reasons stated in the accompanying Memorandum Opinion, Defendants' Motion to Dismiss is GRANTED. All remaining Motions are DENIED AS MOOT.

Let the Clerk send a copy of this Order to all counsel of record.

It is SO ORDERED.

/s/
James R. Spencer
United States District Judge

ENTERED this 18th day of February 2014.

APPENDIX C

42 U.S.C. §18031 (ACA § 1311)

§18031. Affordable choices of health benefit plans

(a) Assistance to States to establish American Health Benefit Exchanges

(1) Planning and establishment grants.--There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after March 23, 2010, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

(2) Amount specified.--For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available to each State for grants under this subsection.

(3) Use of funds.--A State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange, as described in subsection (b).

(4) Renewability of grant.--

(A) In general.--Subject to subsection (d)(4), the Secretary may renew a grant awarded under paragraph (1) if the State recipient of such grant-

(i) is making progress, as determined by the Secretary, toward-

(I) establishing an Exchange; and

(II) implementing the reforms described in subtitles A and C (and the amendments made by such subtitles); and

(ii) is meeting such other benchmarks as the Secretary may establish.

(B) Limitation.-- No grant shall be awarded under this subsection after January 1, 2015.

(5) Technical assistance to facilitate participation in SHOP Exchanges.-- The Secretary shall provide technical assistance to States to facilitate the participation of qualified small businesses in such States in SHOP Exchanges.

(b) American Health Benefit Exchanges.--

(1) In general.-- Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title 1 as an "Exchange") for the State that-

(A) facilitates the purchase of qualified health plans;

(B) provides for the establishment of a Small Business Health Options Program (in this title 1 referred to as a "SHOP Exchange") that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and

(C) meets the requirements of subsection (d).

(2) Merger of individual and SHOP Exchanges.--A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers.

(c) Responsibilities of the Secretary.--

(1) In general.--The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum-

(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act [42 U.S.C. 300gg–1(c)]), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act [42 U.S.C. 256b(a)(4)] and providers described in section 1927(c)(1)(D)(i)(IV) of the

Social Security Act [42 U.S.C. 1396r–8(c)(1)(D)(i)(IV)] as set forth by section 221 of Public Law 111–8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

(D)(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or

(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;

(E) implement a quality improvement strategy described in subsection (g)(1);

(F) utilize a uniform enrollment form that qualified individuals and qualified employers may use (either electronically or on paper) in enrolling in qualified health plans offered through such Exchange, and that takes into account criteria that the National Association

of Insurance Commissioners develops and submits to the Secretary;

(G) utilize the standard format established for presenting health benefits plan options;

(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act [42 U.S.C. 280j–2], as applicable; and

(I) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act [42 U.S.C. 1320b–9a].

(2) Rule of construction.--Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

(3) Rating system.--The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4).

(4) Enrollee satisfaction system.--The Secretary shall develop an enrollee satisfaction survey

system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction information in the information provided to individuals and employers through the Internet portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.

(5) Internet portals.--

The Secretary shall-

(A) continue to operate, maintain, and update the Internet portal developed under section 18003(a) of this title and to assist States in developing and maintaining their own such portal; and

(B) make available for use by Exchanges a model template for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost-sharing reduction, and to present standardized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health insurance choices.

Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the

uniform outline of coverage the plan is required to provide under section 2716 1 of the Public Health Service Act and to a copy of the plan's written policy.

(6) Enrollment periods.--The Secretary shall require an Exchange to provide for-

(A) an initial open enrollment, as determined by the Secretary (such determination to be made not later than July 1, 2012);

(B) annual open enrollment periods, as determined by the Secretary for calendar years after the initial enrollment period;

(C) special enrollment periods specified in section 9801 of title 26 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.]; and

(D) special monthly enrollment periods for Indians (as defined in section 1603 of title 25).

(d) Requirements.--

(1) In general.--An Exchange shall be a governmental agency or nonprofit entity that is established by a State.

(2) Offering of coverage.--

(A) In general.--An Exchange shall make available qualified health plans to qualified individuals and qualified employers.

(B) Limitation.--

(i) In general.--An Exchange may not make available any health plan that is not a qualified health plan.

(ii) **Offering of stand-alone dental benefits.**--Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of title 26 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 18022(b)(1)(J) of this title).

(3) **Rules relating to additional required benefits.**--

(A) **In general.**--Except as provided in subparagraph (B), an Exchange may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 18022(b) of this title.

(B) **States may require additional benefits.**--

(i) **In general.**--Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 18022(b) of this title.

(ii) **State must assume cost.**--A State shall make payments-

(I) to an individual enrolled in a qualified health plan offered in such State; or

(II) on behalf of an individual described in subclause (I) directly to the qualified

health plan in which such individual is enrolled;

to defray the cost of any additional benefits described in clause (i).

(4) **Functions.**--An Exchange shall, at a minimum-

(A) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (c), of health plans as qualified health plans;

(B) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(C) maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);

(E) utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the Public Health Service Act [42 U.S.C. 300gg–15];

(F) in accordance with section 18083 of this title, inform individuals of eligibility requirements for the medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], the CHIP program under title

XXI of such Act [42 U.S.C. 1397aa et seq.], or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;

(G) establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of title 26 and any costsharing reduction under section 18071 of this title;

(H) subject to section 18081 of this title, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of title 26, an individual is exempt from the individual requirement or from the penalty imposed by such section because-

(i) there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(ii) the individual meets the reqirements for any other such exemption from the individual responsibility requirement or penalty;

(I) transfer to the Secretary of the Treasury-

(i) a list of the individuals who are issued a certification under subparagraph (H), including the name and taxpayer identification number of each individual;

(ii) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of title 26 because-

(I) the employer did not provide minimum essential coverage; or

(II) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such title to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(iii) the name and taxpayer identification number of each individual who notifies the Exchange under section 18081(b)(4) of this title that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation);

(J) provide to each employer the name of each employee of the employer described in subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and

(K) establish the Navigator program described in subsection (i).

(5) **Funding limitations.**--

(A) No Federal funds for continued operations.--In establishing an Exchange under this section, the State shall ensure that such

Exchange is selfsustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.

(B) Prohibiting wasteful use of funds.--In carrying out activities under this subsection, an Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications.

(6) Consultation.--An Exchange shall consult with stakeholders relevant to carrying out the activities under this section, including-

(A) educated health care consumers who are enrollees in qualified health plans;

(B) individuals and entities with experience in facilitating enrollment in qualified health plans;

(C) representatives of small businesses and self-employed individuals;

(D) State Medicaid offices; and

(E) advocates for enrolling hard to reach populations.

(7) Publication of costs.--An Exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange, and the administrative costs of such Exchange, on an Internet website to educate

consumers on such costs. Such information shall also include monies lost to waste, fraud, and abuse.

(e) **Certification.**--

(1) **In general.**--An Exchange may certify a health plan as a qualified health plan if-

(A) such health plan meets the requirements for certification as promulgated by the Secretary under subsection (c)(1); and

(B) the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, except that the Exchange may not exclude a health plan-

(i) on the basis that such plan is a fee-for-service plan;

(ii) through the imposition of premium price controls; or

(iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

(2) **Premium considerations.**--The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange shall take this information, and the information and the recommendations provided to the Exchange by the State under section

2794(b)(1) of the Public Health Service Act [42 U.S.C. 300gg–94(b)(1)] (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.

(3) Transparency in coverage.--

(A) In general.--The Exchange shall require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, accurate and timely disclosure of the following information:

(i) Claims payment policies and practices.

(ii) Periodic financial disclosures.

(iii) Data on enrollment.

(iv) Data on disenrollment.

(v) Data on the number of claims that are denied.

(vi) Data on rating practices.

(vii) Information on cost-sharing and payments with respect to any out-of-network coverage.

(viii) Information on enrollee and participant rights under this title.

(ix) Other information as determined appropriate by the Secretary.

(B) Use of plain language.--The information required to be submitted under subparagraph (A) shall be provided in plain language. The term "plain language" means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

(C) Cost sharing transparency.--The Exchange shall require health plans seeking certification as qualified health plans to permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an Internet website and such other means for individuals without access to the Internet.

(D) Group health plans.--The Secretary of Labor shall update and harmonize the Secretary's rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure

with the standards established by the Secretary under subparagraph (A).

(f) **Flexibility.**--

(1) Regional or other interstate exchanges.--An Exchange may operate in more than one State if-

(A) each State in which such Exchange operates permits such operation; and

(B) the Secretary approves such regional or interstate Exchange.

(2) Subsidiary Exchanges.--A State may establish one or more subsidiary Exchanges if-

(A) each such Exchange serves a geographically distinct area; and

(B) the area served by each such Exchange is at least as large as a rating area described in section 2701(a) of the Public Health Service Act [42 U.S.C. 300gg(a)].

(3) Authority to contract.--

(A) In general.--A State may elect to authorize an Exchange established by the State under this section to enter into an agreement with an eligible entity to carry out 1 or more responsibilities of the Exchange.

(B) Eligible entity.--In this paragraph, the term "eligible entity" means-

(i) a person-

(I) incorporated under, and subject to the laws of, 1 or more States;

(II) that has demonstrated experience on a State or regional basis in the individual and small group health

insurance markets and in benefits coverage; and

(III) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of title 26 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(ii) the State medicaid agency under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

(g) Rewarding quality through market-based incentives.--

(1) Strategy described.--A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for-

(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

(D) the implementation of wellness and health promotion activities; and

(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

(2) Guidelines.--The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

(3) Requirements.--The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).

(h) Quality improvement.--

(1) Enhancing patient safety.--Beginning on January 1, 2015, a qualified health plan may contract with-

(A) a hospital with greater than 50 beds only if such hospital-

(i) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act [42 U.S.C. 299b–21 et seq.]; and

(ii) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or

(B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.

(2) **Exceptions.**--The Secretary may establish reasonable exceptions to the requirements described in paragraph (1).

(3) **Adjustment.**--The Secretary may by regulation adjust the number of beds described in paragraph (1)(A).

(i) **Navigators.**--

(1) **In general.**--An Exchange shall establish a program under which it awards grants to entities described in paragraph (2) to carry out the duties described in paragraph (3).

(2) **Eligibility.**--

(A) **In general.**--To be eligible to receive a grant under paragraph (1), an entity shall demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or selfemployed individuals likely to be qualified to enroll in a qualified health plan.

(B) Types.--Entities described in subparagraph (A) may include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration, other licensed insurance agents and brokers, and other entities that-

(i) are capable of carrying out the duties described in paragraph (3);

(ii) meet the standards described in paragraph (4); and

(iii) provide information consistent with the standards developed under paragraph (5).

(3) Duties.--An entity that serves as a navigator under a grant under this subsection shall-

(A) conduct public education activities to raise awareness of the availability of qualified health plans;

(B) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of title 26 and cost-sharing reductions under section 18071 of this title;

(C) facilitate enrollment in qualified health plans;

(D) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health

Service Act [42 U.S.C. 300gg–93], or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and

(E) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.

(4) Standards.--

(A) In general.--The Secretary shall establish standards for navigators under this subsection, including provisions to ensure that any private or public entity that is selected as a navigator is qualified, and licensed if appropriate, to engage in the navigator activities described in this subsection and to avoid conflicts of interest. Under such standards, a navigator shall not-

(i) be a health insurance issuer; or

(ii) receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

(5) Fair and impartial information and services.--The Secretary, in collaboration with States, shall develop standards to ensure that information made available by navigators is fair, accurate, and impartial.

(6) **Funding.**--Grants under this subsection shall be made from the operational funds of the Exchange and not Federal funds received by the State to establish the Exchange.

(j) **Applicability of mental health parity.**--Section 2726 of the Public Health Service Act [42 U.S.C. 300gg–26] shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.

(k) **Conflict.**--An Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under this subchapter.

42 U.S.C. §18041 (ACA § 1321)

§18041. State flexibility in operation and enforcement of Exchanges and related requirements

(a) Establishment of standards.--

(1) In general.--The Secretary shall, as soon as practicable after March 23, 2010, issue regulations setting standards for meeting the requirements under this title, and the amendments made by this title, with respect to-

(A) the establishment and operation of Exchanges (including SHOP Exchanges);

(B) the offering of qualified health plans through such Exchanges;

(C) the establishment of the reinsurance and risk adjustment programs under part E; and

(D) such other requirements as the Secretary determines appropriate.

The preceding sentence shall not apply to standards for requirements under subtitles A and C (and the amendments made by such subtitles) for which the Secretary issues regulations under the Public Health Service Act [42 U.S.C. 201 et seq.].

(2) Consultation.--In issuing the regulations under paragraph (1), the Secretary shall consult with the National Association of Insurance Commissioners and its members and with health insurance issuers, consumer organizations, and such other individuals as the Secretary selects in a manner designed to ensure balanced representation among interested parties.

(b) State action.--Each State that elects, at such time and in such manner as the Secretary may prescribe, to apply the requirements described in subsection (a) shall, not later than January 1, 2014, adopt and have in effect-

(1) the Federal standards established under subsection (a); or

(2) a State law or regulation that the Secretary determines implements the standards within the State.

(c) Failure to establish Exchange or implement requirements.--

(1) In general.--

If-

(A) a State is not an electing State under subsection (b); or

(B) the Secretary determines, on or before January 1, 2013, that an electing State-

(i) will not have any required Exchange operational by January 1, 2014; or

(ii) has not taken the actions the Secretary determines necessary to implement-

(I) the other requirements set forth in the standards under subsection (a); or

(II) the requirements set forth in subtitles A and C and the amendments made by such subtitles;

the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.

(2) **Enforcement authority.**--The provisions of section 2736(b) 1 of the Public Health Services 2 Act [42 U.S.C. 300gg–22(b)] shall apply to the enforcement under paragraph (1) of requirements of subsection (a)(1) (without regard to any limitation on the application of those provisions to group health plans).

(d) **No interference with State regulatory authority.**--Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.

(e) **Presumption for certain State-operated Exchanges.**--

(1) **In general.**--In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards.

(2) **Process.**--The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section.

26 U.S.C. §36B (ACA § 1401(a))

§36B. Refundable credit for coverage under a qualified health plan

(a) In general.--In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year.

(b) Premium assistance credit amount.--For purposes of this section-

(1) **In general.**--The term "premium assistance credit amount" means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.

(2) **Premium assistance amount.**--The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of-

(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under 1311 1 of the Patient Protection and Affordable Care Act, or

(B) the excess (if any) of-

(i) the adjusted monthly premium for such month for the applicable second lowest cost

silver plan with respect to the taxpayer, over

(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

(3) Other terms and rules relating to premium assistance amounts.--For purposes of paragraph (2)-

(A) Applicable percentage.--

(i) In general.--Except as provided in clause (ii), the applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income is within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier:

In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is-	The final premium percentage is-
Up to 133%	2.0%	2.0%
133% up to 150%	3.0%	4.0%
150% up to 200%	4.0%	6.3%
200% up to 250%	6.3%	8.05%
250% up to 300%	8.05%	9.5%
300% up to 400%	9.5%	9.5%.

(ii) **Indexing.**--

(I) In general.--Subject to subclause (II), in the case of taxable years beginning in any calendar year after 2014, the initial and final applicable percentages under clause (i) (as in effect for the preceding calendar year after application of this clause) shall be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year.

(II) Additional adjustment.--Except as provided in subclause (III), in the case of any calendar year after 2018, the percentages described in subclause (I) shall, in addition to the adjustment under subclause (I), be adjusted to reflect the excess (if any) of the rate of premium growth estimated under subclause (I) for the preceding calendar year over the rate of growth in the consumer price index for the preceding calendar year.

(III) Failsafe.--Subclause (II) shall apply for any calendar year only if the aggregate amount of premium tax credits under this section and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act for the preceding calendar year exceeds an amount equal to 0.504 percent of the gross domestic product for the preceding calendar year.

(B) Applicable second lowest cost silver plan.-- The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which-

(i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and

(ii) provides-

(I) self-only coverage in the case of an applicable taxpayer-

(aa) whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 for the taxable year with respect to a dependent, or

(bb) who is not described in item (aa) but who purchases only self-only coverage, and

(II) family coverage in the case of any other applicable taxpayer.

If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (ii)(I) unless a deduction is allowed under section 151 for the taxable year with respect to a dependent

other than either spouse and subsection (e) does not apply to the dependent.

(C) Adjusted monthly premium.--The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the premiums under paragraph (2)(A) were determined) for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

(D) Additional benefits.—

If-

(i) a qualified health plan under section 1302(b)(5) of the Patient Protection and Affordable Care Act offers benefits in addition to the essential health benefits required to be provided by the plan, or

(ii) a State requires a qualified health plan under section 1311(d)(3)(B) of such Act to cover benefits in addition to the essential health benefits required to be provided by the plan,

the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such additional benefits shall not be taken into account in determining either the monthly premium or the adjusted monthly pr mium under paragraph (2).

(E) Special rule for pediatric dental coverage.--For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) 2 of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.

(c) Definition and rules relating to applicable taxpayers, coverage months, and qualified health plan.--For purposes of this section-

(1) Applicable taxpayer.--

(A) In general.--The term "applicable taxpayer" means, with respect to any taxable year, a taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.

(B) Special rule for certain individuals lawfully present in the United States.--

If-

(i) a taxpayer has a household income which is not greater than 100 percent of an amount equal to the poverty line for a family of the size involved, and

(ii) the taxpayer is an alien lawfully present in the United States, but is not eligible for the medicaid program under title XIX of the Social Security Act by reason of such alien status, the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.

(C) Married couples must file joint return.--If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, the taxpayer shall be treated as an applicable taxpayer only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

(D) Denial of credit to dependents.--No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

(2) Coverage month.--For purposes of this subsection-

(A) **In general.**--The term "coverage month" means, with respect to an applicable taxpayer, any month if-

(i) as of the first day of such month the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer is covered by a qualified health plan described in subsection (b)(2)(A) that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and

(ii) the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act).

(B) **Exception for minimum essential coverage.**--

(i) **In general.**--The term "coverage month" shall not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

(ii) **Minimum essential coverage.**--The term "minimum essential coverage" has the meaning given such term by section 5000A(f).

(C) **Special rule for employer-sponsored minimum essential coverage.**-- For purposes of subparagraph (B)-

(i) **Coverage must be affordable.**--Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage-

(I) consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)), and

(II) the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.5 percent of the applicable taxpayer's household income.

This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.

(ii) **Coverage must provide minimum value.**--Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

(iii) **Employee or family must not be covered under employer plan.**-- Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eligible employer-sponsored plan or the grandfathered health plan.

(iv) Indexing.--In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent under clause (i)(II) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

(3) **Definitions and other rules.**--

(A) Qualified health plan.--The term "qualified health plan" has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

(B) Grandfathered health plan.--The term "grandfathered health plan" has the meaning given such term by section 1251 of the Patient Protection and Affordable Care Act.

(d) **Terms relating to income and families.**--For purposes of this section-

(1) Family size.--The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(2) Household income.--

(A) Household income.--The term "household income" means, with respect to any taxpayer, an amount equal to the sum of-

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who-

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(B) Modified adjusted gross income.--The term "modified adjusted gross income" means adjusted gross income increased by-

(i) any amount excluded from gross income under section 911,

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax, and

(iii) an amount equal to the portion of the taxpayer's social security benefits (as defined in section 86(d)) which is not included in gross income under section 86 for the taxable year.

(3) Poverty line.--

(A) In general.--The term "poverty line" has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

(B) Poverty line used.--In the case of any qualified health plan offered through an Exchange for coverage during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular

enrollment period for coverage during such calendar year.

(e) Rules for individuals not lawfully present

(1) In general.--If 1 or more individuals for whom a taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year (including the taxpayer or his spouse) are individuals who are not lawfully present-

(A) the aggregate amount of premiums otherwise taken into account under clauses (i) and (ii) of subsection (b)(2)(A) shall be reduced by the portion (if any) of such premiums which is attributable to such individuals, and

(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

(i) A method under which-

(I) the taxpayer's family size is determined by not taking such individuals into account, and

(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction-

(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

(ii) A comparable method reaching the same result as the method under clause (i).

(2) Lawfully present.--For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the credit under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

(3) Secretarial authority.--The Secretary of Health and Human Services, in consultation with the Secretary, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

(f) Reconciliation of credit and advance credit.--

(1) In general.--The amount of the credit allowed under this section for any taxable year shall be reduced (but not below zero) by the amount of any advance payment of such credit under section 1412 of the Patient Protection and Affordable Care Act.

(2) Excess advance payments

(A) In general.--If the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed by this section (determined without regard to paragraph (1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

(B) Limitation on increase

(i) In general.--In the case of a taxpayer whose household income is less than 400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed the applicable dollar amount determined in accordance with the following table (one-half of such amount in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year):

If the household income (expressed as a percent of poverty line) is:	The applicable dollar amount is:
Less than 200%	$600
At least 200% but less than 300%	$1,500
At least 300% but less than 400%	$2,500.

(ii) Indexing of amount.--In the case of any calendar year beginning after 2014, each of the dollar amounts in the table contained under clause (i) shall be increased by an amount equal to-

(I) such dollar amount, multiplied by

(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting "calendar year 2013" for "calendar year 1992" in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(3) Information requirement.--Each Exchange (or any person carrying out 1 or more responsibilities of an Exchange under section 1311(f)(3) or 1321(c) of the Patient Protection and Affordable Care Act) shall provide the following information to the Secretary and to the taxpayer with respect to any health plan provided through the Exchange:

(A) The level of coverage described in section 1302(d) of the Patient Protection and Affordable Care Act and the period such coverage was in effect.

(B) The total premium for the coverage without regard to the credit under this section or cost-sharing reductions under section 1402 of such Act.

(C) The aggregate amount of any advance payment of such credit or reductions under section 1412 of such Act.

(D) The name, address, and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy.

(E) Any information provided to the Exchange, including any change of circumstances,

necessary to determine eligibility for, and the amount of, such credit.

(F) Information necessary to determine whether a taxpayer has received excess advance payments.

(g) Regulations.--The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for-

(1) the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act, and

(2) the application of subsection (f) where the filing status of the taxpayer for a taxable year is different from such status used for determining the advance payment of the credit.